SCOTTISH HEALTH SERVICES COUNCIL

Hospital Catering

Report by a Joint Committee of the Standing Medical Advisory Committee and the Standing Advisory Committee on Hospital and Specialist Services

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Joint Committee of the Standing Medical Advisory Committee and the Standing Advisory Committee on Hospital and Specialist Services

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HOSPITAL CATERING

PART I

Introduction

Appointment and Terms of Reference

1. We were appointed by the Scottish Health Services Council in 1959 basically as a Joint Committee of the Standing Medical Advisory Committee and the Hospital and Specialist Services Committee. Our remit was:

> "To review the catering services in hospitals with particular reference to the medical requirements of these services, the arrangements for training catering personnel and the instruction of hospital staffs generally; and to make recommendations."

Procedure of the Committee

2. Early in our deliberations we concluded that the medical aspects of our remit should be considered in the first instance by the medical members of the Committee. The medical group met separately on 2 occasions and we met in full Committee 12 times.

3. We have received and studied written evidence from 13 bodies; the latter are detailed in Appendix A to the Report. In addition we have had oral evidence from representatives of 14 organisations (detailed in Appendix B); and in the course of our review members of the Committee have visited the hospitals and other establishments listed in Appendix C.

Circumstances leading to our Appointment

4. Despite its importance there has not, since the inception of the National Health Service, been any general enquiry into catering in the Scottish hospital service. The appointment of our Committee derived not so much from any adverse criticism of present standards of hospital catering as from a general desire that the hospital catering service should be equipped to play its part in the changing hospital scene. The hospital service is now in an era of major new building and modernisation. There is in train a radical break away from the "Nightingale" pattern of hospitals inherited by the National Health Service; and traditional hospital procedures of all kinds are being reviewed. In this new climate it is important that the hospital catering service should shed any vestigial practices of an "institutional" kind. It was against this background that we were appointed.

Assessment of Current Situation

5. Hospital catering before 1948 was, by and large, "institutional" in character. There were few specialised catering departments responsible for the whole range of food service activities; responsibility for the catering services was frequently divided; catering staff were without proper status; purchasing arrangements were often unsatisfactory; and meals in hospitals for both patients and staff were too frequently poor in quality, inadequate in quantity and monotonous. There was a tendency to accept such conditions because hospitals had a different status in the community from that which they now have.

6. Our visits to hospitals throughout Scotland have enabled us to take stock of the present state of the hospital catering service. We have consistently sought consumer reaction and, in our experience, criticism of catering in hospitals, when it arises, tends to come from staff more than from patients. This is understandable. Patients in the main are transient consumers of hospital food; but staff may have a long-term connection with a particular hospital and in such circumstances even a high standard of catering can pall after a time.

7. This is not to say that all patients are satisfied and that all staff grievances are unjustified. Some hospitals we have visited seem to have a competent catering staff producing good results despite obvious shortcomings in the premises and equipment at their disposal; at others the high standard of facilities was not always matched by the abilities of the staff. Fortunately, it rarely happens that all the factors which conduce to poor catering standards are present at one time: when it does occur, the depressive effect on hospital morale is marked.

8. We are satisfied that the appointment since 1948 of expert catering officers in hospitals and groups of hospitals has eliminated many of the worst features of institutional catering. There is still some unevenness in standards; but except in regard to one or two items (e.g., fruit) patients and staff—and certainly the patients and staff in general hospitals—are reasonably well fed. In some cases excellent standards are maintained. There is variety to the extent that standing orders for provisions and their concomitant evil, standing menus, have been discarded. Systematic buying on the basis of properly planned menus is now fairly general. Skilled portion-control is generally practised but there is no rigid financial control or system equivalent to rationing such as was typical of institutional catering in the pre-National Health Service days. In short, considerable improvements have been effected.

9. Nevertheless certain inadequacies and shortages are still being made up by gifts of food, etc., from visitors although such gifts may often be the result of ingrained habit rather than necessity. There is still some lack of variety because kitchens are not always adequately equipped and there are not always sufficient trained staff to provide a highly varied diet. There is not regularly a choice of menu for staff and there is only rarely such a choice for patients. There is still excessive "plate waste" in many hospitals. And catering "standards" still tend to be financial rather than nutritional.

10. An unfriendly environment militates against the recovery of the patient, and affects staff adversely. Hospital authorities are striving to escape from the bleakness which was typical of the 19th century institution to hospitals designed to meet modern human needs and social standards. The same sensible approach is called for in the sphere of catering which is one of the most human of all activities. The French have a saying that communities begin by establishing their kitchens; and from time immemorial food has been the concrete symbol of

human warmth and friendliness. The atmosphere of a hospital depends to a significant degree on the excellence or otherwise of its catering arrangements. No matter how attractive any hospital might otherwise be—whether in terms of design, standard of furnishing, standard of treatment or location—it will be adversely judged by patients admitted to it and staff working in it if the food served does not come up to acceptable standards.

11. In the past, attention was focussed largely on the patient's pathological symptoms. What was normal and healthy in his condition was overlooked. In particular, insufficient heed was paid to his nutritional needs. Moreover, the role of the therapeutic dietitian was (and still is) only imperfectly understood. Hospitals should, in our view, set nutritional standards capable of having an educational influence on the community. They are still a long way from doing so.

Outline of Our Report

12. We have come to the conclusion that a more positive attitude to hospital catering on the part of the responsible authorities is overdue. The faults of institutional catering stemmed from an excessive emphasis on the collective as against the individual aspects of catering on a large scale. But large scale catering is something more than catering on a large scale; and attention must now be directed to the individual nutritional requirements of patients and staff.

13. Catering for the individual is, therefore, in our view, the most significant contribution that the hospital catering service can make to the revolution in regard to the care and treatment of patients and the management of staff which is steadily taking place in our hospitals in response to contemporary medical and social pressures. If conscientious efforts are made to meet individual requirements to the greatest extent possible within a collective system we are confident that the quality of meals will improve and that the maximum physiological and psychological benefit will be derived from their consumption.

14. We have considered this main objective first in relation to patients and secondly in relation to staff. We have also considered the purchasing arrangements for provisions; kitchens and hygiene; organisation and staffing; the role of other staff in relation to the catering service; and central planning and control. We deal in some detail with all of these topics in our Report in the order in which they have been mentioned.

PART II

Nutritional Requirements of Patients

15. What standard of dietary is the hospital service to aim at? In a sphere where the issues are so often clouded by subjective reactions, broad objective standards are particularly necessary. The essential aim should be to give to every patient acceptable meals, adequate to repair any previous dietary deficiencies and to provide for current nutritional needs.

16. It is logical first to consider the general dietary or nutritional requirements of patients and secondly the particular needs of patients whose clinical condition requires special dietary arrangements.

17. It is an important physiological truth that the condition of the human body can vary remarkably from one individual to another according to the quantity and quality of the previous diet. The ability of the body to withstand and overcome disease may be determined decisively by its condition. It is for this reason that satisfactory nutritional standards are a prerequisite of medical treatment.

18. In considering standards of diet, we found helpful information in the following documents:

(1) Report of the Committee on Nutrition (B.M.A. 1950).
(2) Third Memorandum on Hospital Diet (King Edward's Hospital Fund for London, April, 1959).
(3) Report of an Inquiry into the Nutritive Value of Meals Provided in Various Hospitals in West Cornwall, by Professor Platt and colleagues (Nuffield Provincial Hospitals Trust, 1959).

These authoritative reports contain a great deal of information and advice about dietary standards, but we have confined ourselves to recording our conclusions on the subject in the context of the Scottish hospital service.

19. At the outset we should say that we found it impossible to lay down a uniform nutritional standard against which the catering in any hospital could be judged. Essential needs vary from one hospital to another according to the nature of the patient population. Hospitals catering chiefly for acutc conditions, aged chronic sick, mental patients, children or maternity cases will all have different requirements. Further variable factors are whether the patients are ambulant or confined to bed; and how much additional food is brought in to them by visitors. Even with precise information on such factors it is not possible at present to lay down any uniform nutritional standards because of thc lack of accurate iuformation on nutritional requirements under differcnt clinical circumstances.

20. The food required by patients is determined by the energy they expend and by their other nutritional needs. With adequate research it might be possible to indicate more precisely how much food a given hospital ought to provide, granted a sufficient knowledge of the age, sex, activity and diseases of its patients. Such precision, however, in estimating food requirements is unlikely to materialise for a long time. This does not mean that nothing can be done. The hospital catering service, if it can develop sufficient flexibility, should, within broad limits, be able to provide for individual needs a standard of diet which is nutritionally sound and suitably varied.

Nutritive Value of Hospital Diets

21. The main elements in the nutritive value of food, in the short run, are the energy (calorie), protein and vitamin C content. In the long run, where patients (and staff) are in hospital for considerable periods of time, other vitamins are of importance; and so are minerals.

Calories (kilogramme calorie)

. From the point of view of Caloric requirements, hospital patients fall into four broad groups. Caloric intake has to be sufficient but not excessive, and we

would suggest that while the needs of individual patients must vary the average Caloric requirement in each of these groups is as follows:

For adults of normal weight in bed—2,000 Cal./day
For growing adolescents in bed —2,500 Cal./day
For ambulant adults —2,500 Cal./day (more if underweight or engaged in work)
For ambulant nursing mothers —3,500 Cal./day

As a broad yardstick we would say that in planning menus for a large hospital dealing mainly with adults confined to bed a ration of 2,000 Cal./day per patient should be adequate. In catering for the elderly, however, it has to be kept in mind that, while the requirement for calories may fall, the need for vitamins and other nutrients may increase.

Proteins

We agree with the King Edward's Fund recommendation that the protein allowance should ordinarily provide 14 per cent of the calories though allowance should be higher for patients recovering from operations or injuries. Hospitals dealing with such cases should never be stinting in their provision of meat, poultry, eggs, milk and cheese, particularly during convalescence.

Vitamin C (ascorbic acid)

An adequate supply of this vitamin is essential for the maintenance of health and the proper healing of wounds. It is supplied by many fresh fruits (especially citrous fruits) and by many vegetables; but it is imperative that these items should be properly handled in the hospital kitchen. Much of the nutritive value of vegetables is lost if they are prepared well in advance of the meal and allowed to soak in water for a considerable time before cooking. Where this practice exists the kitchen routine should be adjusted so that it is no longer necessary. Cooking should also take place as near to the time of the meal as possible. Some authorities are unable to purchase the necessary quantities of fresh fruit on grounds of expense. We recommend the inclusion of sufficient fruit and vegetables in all hospital menus.

Special Needs of Children

22. The composition of diets for children in hospital depends largely on their age and the nature of their illness; and the catering arrangements for the provision of such diets depend in turn on the type and size of the hospital. Appropriate catering arrangements are easier to make in a children's hospital where everything is attuned to the care of children than in a children's unit in a general hospital dealing mainly with the care of adults.

23. Three types of normal diet are necessary for babies and children:

(1) Milk diet.
(2) Transitional (weaning) diet.
(3) Adult diet suitably supplemented as required.

24. Special facilities in the form of a specially equipped and staffed milk kitchen are necessary for the preparation of milk feeds but standard catering arrangements should be adequate for the provision of transitional and adult type diets. Choice of menu is not applicable to young children though it would be to older school-age children. At all ages the therapeutic importance of studying the food likes and dislikes of children should be appreciated.

Needs of patients in mental and mental deficiency hospitals

25. One feature in current dietary standards merits forthright criticism. In mental hospitals, and particularly in mental deficiency hospitals, the cost per person fed tends to be substantially lower than in other types of hospital. This seems to us somewhat paradoxical. A high proportion of the patients in mental and mental deficiency hospitals are physically well and active and have normal appetites. We are in no doubt that part of the explanation for the lower cost of feeding at hospitals of this type lies in the lower standard—both in quality and variety—of food provided to patients. This is not a new situation. It has, we understand, always been so. But there is no reason to think that, in general, gastronomic indifference goes with mental illness or mental deficiency. Efforts have already been made to improve feeding standards and conditions at mental and mental deficiency hospitals. We think that this trend needs a sharp impetus. Accordingly we recommend that the Boards of Management concerned should be asked to examine critically the dietary standards in their hospitals—and indeed catering facilities generally in their hospitals—and be given extra funds specially to improve standards where necessary.

Section 2. Therapeutic Diets

26. The prescription of special diets for the treatment of disease is an ancient part of the art of medicine and one that was flourishing in the time of Hippocrates. It is only in the past 50 years, however, that dietetics has become a practical science.

27. The teaching of dietetics in medical and nursing schools has not always kept pace with recent notable advances in nutritional science. It is no longer necessary, for example, for a doctor to prescribe elaborate dietary regimens for the treatment of peptic ulcer or gout; nor is it necessary for a nurse to continue to learn how to make beef tea or barley water. Although some of the new basic science of nutrition is generally taught to students, it is not always sufficiently related to the practical problem of providing patients with the correct food, in proper proportions and tastefully served. There is also a definite need in modern hospital practice for the services of qualified dietitians to a greater extent than is at present provided. We deal with all of these aspects in Part VIII of our Report in more detail.

Different kinds of therapeutic diet

28. While all diets have some therapeutic value, there are two broad divisions that we would make. First, there are the diets with an accurately controlled nutrient composition which have a particular therapeutic value in certain clinical conditions. Such diets normally require the supervision and attention of a qualified dietitian if the doctor's precise prescription is to be properly fulfilled; otherwise the food provided may differ markedly in nutrient composition from the intentions of the doctor. The diets in this category include those for diabetes, obesity (under 1,000 calories), malabsorption and certain types of liver, kidney and heart disease. Controlled diets are also needed for a variety of diagnostic tests. All such controlled diets should be provided from the diet kitchen.

29. Secondly, there are certain pathological conditions where proper regulation of the patient's diet may bring considerable benefit. These conditions

include wasting diseases, prolonged fevers, irritative lesions of the gut, difficulties in taking food, burns, fractures and other surgical cases, both before and after operation. In these, and other conditions, the advice and attention of a dietitian is often valuable. In such cases, however, the diet should be provided by the main hospital kitchen, as should the traditional "light diet".

30. A further reference to diets of therapeutic value is contained in Appendix D: this Appendix reproduces a memorandum prepared by the late Dr. Meiklejohn.

Number of therapeutic diets needed

31. The number of "special" diets ordered by doctors for hospital patients is sometimes unnecessarily large. Such diets may be ordered merely to give the patient an alternative menu. Unnecessary "special" diets may also be requested through an insufficient understanding of the scope and limitations of modern dietary therapy.

32. On the available evidence, only 10 to 15 per cent of the patients in a general hospital should require controlled therapeutic diets under present day conditions. In saying this we do not under-rate the value and importance of such diets; with proper use they may influence decisively the course of a disease. But they should be used with discrimination. We recommend, accordingly, that any general hospital which is regularly providing more than 15 per cent of its patients with therapeutic diets involving the supervision and attention of a qualified dietitian should critically examine its practice.

Diet kitchens

33. The diet kitchen should be a place set aside for the preparation of controlled therapeutic diets. It ought to be adjacent to the main hospital kitchen or be a separate bay within the main kitchen so that the dietitian can easily obtain her supplies from the main store and take advantage wherever possible of the ordinary catering services. There is no justification for the diet kitchen separately ordering and preparing potatoes, etc., which could conveniently be supplied by the main kitchen. Controlled diets, individually labelled, should travel to the wards in containers or trays in the main food trolley rather than separately.

34. In teaching hospitals engaged in research an additional diet kitchen attached to the metabolic ward is essential.

35. The dietitian should have adequate staff of her own for cooking, although not necessarily for cleaning. She should also have adequate space for interviewing patients, preparing menus, keeping records, and for reference books and professional periodicals.

Relations between the dietitian and other hospital colleagues

36. The dietitian should regularly visit the patients on therapeutic diets and, if necessary, see them before discharge to ensure that they will continue to follow their dietetic instructions at home. In this the dietitian, the almoner and the ward sister should all co-operate.

37. Effective liaison between the dietitian and medical nursing and catering staff is essential.

Dietetic services in relation to the size and type of hospital

38. Any hospital dealing with acute cases, of 150 heds or over, can usefully employ a full-time dietitian. Larger general hospitals may need more than one. Smaller hospitals on the other hand, and particularly those dealing in the main with chronic cases, have usually insufficient dietetic problems to justify the appointment of a full-time dietitian.

39. Nevertheless nutritional problems continue to arise in small general hospitals, and particularly in geriatric and mental hospitals. We recommend, therefore, that encouragement should he given to the employment of group dietitians who would he availahle to several neighbouring hospitals, each in itself unahle to provide sufficient work for a whole-time dietitian. We deal with this matter more fully in Part VIII of our Report.

PART III

Service of Food to Patients

40. We have already said that proper feeding is a prerequisite of medical treatment and that the essential task of the catering service is to provide patients with acceptahle meals, adequate to repair any previous dietary deficiencies and to provide for current nutritional needs. We have also referred to the practical difficulties which must he overcome and to the need for catering departments to develop the maximum flexibility if individual needs are to he met. We now deal with these matters in greater detail.

Section 3. Choice of Menu

41. Success or failure in providing a nutritious diet inevitably depends on what is actually eaten. It is useless to provide a nutritious meal which for some reason or another, e.g., acquired food hahits, is either totally or in part rejected. It is, however, possihle "to eat what we like while eating what we should" and the key to the problem of catering in hospitals lies in the provision of a selective menu which offers as wide a choice as possihle and which does not repeat itself at too frequent intervals. Under such a system patients will he able to select halanced meals suitahle to their particular needs and tastes. Variety is desirable for its own sake: if individual wishes are to he met, it is essential where large numhers are heing catered for. Similarly, choice is desirahle in itself for psychological reasons; and where large numbers are heing catered for it is essential. In our homes reasonahle variety and choice are always availahle. It is largely an unconscious process hecause our likes and dislikes are known. The hospital service must offer conscious variety and choice if it is to improve upon institutional standards and provide in the hospital conditions that approach conditions ohtaining in the home. The adoption of selective menus will meet this need. It will also help to eliminate anomalies such as totally different menus for staff and patients. Choice of menu has also certain indirect advantages in that it facilitates small scale cooking and a hetter utilisation of staff and equipment.

42. We recommend, therefore, that selective menus hased on, say, a six weeks rota, skilfully planned to meet, as far as possible, varying nutritional

needs and offering a reasonable choice of meal should be the standard at which the hospital service should now aim.

43. We further recommend that in order to provide some control over standards sample selective menus suitable for hospital use should be issued at intervals, perhaps by regional catering advisers (to whom we refer in Part VII) in consultation with one another. These sample menus could be assessed from the nutritional point of view and costed. This would give some indication to hospital catering departments of what they should be trying to achieve. In Appendix E we have provided sample menus of the kind we have in mind.

44. An experimental scheme designed to serve alternative dishes to all patients has been in operation in at least one general and one mental hospital in the South-Eastern Hospital Region since 1958. With modifications, made in the light of experience, this experiment has proved successful. Efforts to extend selective menus to other hospitals have met with varying degrees of response and success.

45. A choice of menu system should be capable of implementation in most hospitals even if only on a limited scale at first. It is particularly important to give a choice of menu in hospitals dealing mainly with long-stay patients. We recommend an arrangement of the following kind. Menus giving a choice of dishes for breakfast, lunch and supper should be given to the patients who would make their selection at a suitable interval before each meal. Patients should not be asked to choose more than one meal in advance. A pre-printed perforated menu form suitable for use in hospitals is included in Appendix E.

46. The number of alternatives offered and the successful day to day working of such a system will depend on the particular expertise of the catering officer or person in charge. Adequate knowledge of modern catering practices should enable various combinations of alternatives to be compiled which will provide a satisfactory diet and, at the same time, yield a minimum of "left-overs".

47. One of the disincentives associated with a system of choice of menu by patients is the belief that this will inevitably increase catering costs. Experience has shown that costs need not rise: they may in fact fall. But even if the institution of a choice of menu resulted in some increase in expenditure we consider that the psychological and physiological benefits to the patient would make the extra cost well worthwhile.

Section 4. Distribution of Meals to Patients

48. The central problem of hospital catering is the problem of cooking meals for very large numbers as near to the time of the meals as possible and thereafter distributing the cooked food, with the minimum of handling and the minimum of delay, to the patients. Distribution of food to patients raises special problems, especially in the horizontal type hospitals, because the kitchens are necessarily some distance from the wards. Various methods have been and are being devised to keep food hot while in transit from the kitchen to the patient.

49. The system most frequently found in the Scottish hospital service is the electrically heated trolley which conveys the food in bulk from the kitchen to the ward. This method is most effective when the trolley is taken round the ward to permit bedside service. But the electrically heated trolley system is not without defects. It involves double handling of the food (at the kitchen and in the ward); it cannot readily be geared to such a wide choice of menu as we would like to see introduced; and the plating of the food itself takes up valuable nursing time.

50. If a reasonable choice of dishes is to be available to patients a system of central tray service may have advantages over the system of distribution of food in bulk by electrically heated trolleys. We ourselves have not seen a central tray service under full operational conditions (none existed in Britain when we were making our visits to hospitals); but we did see in an English hospital a token installation of a particular system (the "dri-heat" system) which gave us some idea of the possibilities of this new approach to the distribution of food to patients. The following seem to us to be the main advantages of a central tray service:

(1) It makes possible a wide choice of menu.
(2) It reduces handling of food.
(3) Food conveyed in this way suffers less from condensation and is more palatable on arrival in the wards.
(4) Skilled presentation of food and proper portion control are more readily secured.
(5) Nursing time involved in plating food is saved.
(6) It makes for more mechanisation in the kitchen.
(7) Optimum use of trained nursing and catering staff is obtained.
(8) It simplifies ward kitchen arrangements.

51. There are several systems of central tray service, e.g.:

(1) Trayveyer system whereby meals are taken on moving belts direct from the central kitchen to the ward. (This system is in use in some American hospitals but the serving process is simpler in America because patients seldom have hot puddings and do not expect soup.)
(2) Heated and refrigerated trolleys containing individual trays, with make-up conveyors in the kitchen.
(3) Dri-heat system involving the use of individual trays on which main dishes are kept hot by "pellets".

We think that (2) and (3) are more likely than (1) to provide a solution in line with our existing methods. Moreover, they may be capable of being installed in existing hospitals, although it will often be preferable, on account of the size of the kitchen or other factors, to continue bulk service to a common servery with skilled plated service from this point to a group of wards and the dining accommodation for ambulant patients. Such a compromise arrangement is envisaged for a new psychiatric hospital at present in course of erection.

2. We have not been able to obtain a detailed cost comparison between the central tray service systems and conventional methods of food distribution. In terms of capital cost the newer systems might be more expensive. They also give rise to staffing and supervisory problems in the main kitchen. We recommend, however, that the Department of Health should authorise the early experimental installation of at least the second and third methods (indicated above) of central tray service at selected hospitals in order that some first-hand experience might be obtained of these innovations in the service of food to patients. If any of the central tray service systems were demonstrably superior to the current conventional method the knowledge of this would be helpful to those concerned with the planning of new hospitals and the modernisation of old ones.

Section 5. Service of Food in Wards

53. All the benefits that can derive from the choice of a meal and good cooking in the kitchen will be vitiated if the service of the meal in the ward is defective. Ward routines should be arranged to ensure the prompt service of meals at the appropriate times.

Times of meals

54. The three main meals are not always properly spaced out. In some hospitals patients are wakened at a very early hour with a morning cup of tea and then have to wait a considerable time for breakfast. At the other end of the day, supper is served in some hospitals at too early an hour which means that patients have a long gap between supper and breakfast the following morning.

55. We recommend the following as appropriate times for the three main meals:

Breakfast between 7 and 8;
Lunch between 12 and 1;
Supper not earlier than 6.

Responsibility for serving the patients

56. Traditionally the ward sister and her staff have been responsible for the service of meals. In our view they should continue to bear the responsibility at least for supervising the service of food to patients whether the meals are distributed in bulk as at present or by a central tray service. The nursing staff know the patients as individuals, and are familiar not only with their medical condition and any possible dietary requirements, but also with individual foibles or idiosyncrasies. Where there is a selective menu they have an invaluable part to play in advising about what might be most suitable.

57. It does not follow, however, in our view, that the actual handing of food to the patient need be done by a member of the nursing staff. Where it is possible to train non-nursing ward staff for these duties this should be done. Another method might be for the service to be undertaken by lay staff from the catering departments. This, however, would make unnecessarily heavy demands on the staff in the catering department.

Supervision of ward feeding

58. It should also be normal practice for medical staff to visit their patients periodically at meal times to see for themselves that this part of treatment is well managed. Where there is a keen medical interest catering standards tend to be high. The old tradition that doctors should be away from the wards at meal times lest they distract the nurses from their immediate task of serving meals should give way to informal visits by doctors which can do much to emphasise the interest and importance which the hospital attaches to good nutrition. While such informal visits should be encouraged, formal teaching or clinical rounds at meal times are to be deprecated.

Needs of Ambulant Patients

59. Proper dining facilities should be provided for ambulant patients.

Separate ward dining rooms add to the pleasure of a meal and thus to the nutrition of the patient. Modern hospitals should, therefore, be designed to provide dining room as well as day room accommodation. It will often be possible for wards to share such facilities.

60. Such arrangements are particularly desirable in mental hospitals. The traditional large and unattractive dining halls should be dispensed with. Mental patients should dine in their own ward dining rooms under normal conditions so far as possible. This facilitates proper segregation of the patients; better standards of social conduct can be achieved with small groups; and having their meals in pleasant surroundings will aid the recovery of mentally ill patients. In some newly planned hospitals of this type provision has been made for joint dining rooms for male and female patients as a further step towards the creation of a modern "therapeutic community".

Gifts of food from visitors

61. The custom of bringing gifts of food and beverages to patients in hospital is an old one which derived largely from the poor standards of institutional catering in the past. With improved standards this should no longer be necessary; nor indeed is it altogether desirable as the foods chosen by visitors are not always the most suitable. For example, glucose drinks and confectionery provide only "empty calories" and lack essential vitamins, minerals and protein. They may well vitiate the patient's appetite. Fresh fruit, on the other hand, is a valuable source of vitamin C; but if fruit appeared more regularly on hospital menus there would be less dependence on this type of gift.

62. Ingrained habits of this kind may, of course, outlive the original need for them. We may now perhaps begin to look forward to the time when substantial gifts of food to patients in hospital will cease altogether.

Section 6. The Ward Kitchen and Ward Equipment

Ward Kitchens

63. Every ward unit should have facilities for "sick-room" cookery and preparation of beverages. We envisage a continued need for ward kitchens of this type although it may sometimes be possible to share them between wards. The ward kitchen should be used to meet the immediate nutritional needs of patients but it should never be part of its function to provide regular meals; nor should it ever be needed to make good deficiencies in the food delivered to the wards. Some very helpful guidance on the design and layout of ward kitchens has been issued to hospital authorities by the Department of Health and there is no need for us to enlarge on this topic beyond stressing the fact that even with a central tray service and centralised dish washing the need for a modified ward kitchen will remain.

Plate Waste

64. When catering standards are good (and particularly with a choice of menu) there will be a minimum of plate waste. Where there is no central dish-washing, to which we refer in Part VI, any plate waste in the wards should be disposed of by means of the "wastemaster" type of appliance or in destructible bags.

Ward Equipment

65. Bed patients should be provided with a modern over-bed table. Bedside lockers with pull-out trays are not desirable because they are awkward and uncomfortable.

66. Attractive individual trays each equipped with condiments, milk, sugar, etc., add to the pleasure of the meal and should be provided. In some hospitals tea is also provided in individual pots and this is to be recommended. Cutlery should be clean and pleasant in appearance and of good quality. Chipped or cracked crockery is unsightly and may be a hidden source of bacterial infection. We favour coloured or decorated crockery and have not so far found a completely satisfactory unbreakable substitute.

PART IV

Catering for Staff

67. Although it is different from catering for patients and does not give rise to the same difficulties in regard to distribution and service or to the special problems created by therapeutic diets, nevertheless catering for the varying needs of all the different categories of hospital staff has its own problems. Resident staff must have proper provision made for them. At the same time, generous provision must be made for the increasing numbers of non-resident staff. Night staff must have freshly cooked meals during their tour of duty. The catering department must, therefore, provide for widely varying needs a 24-hour service with the main activity centred on the mid-day meal.

Section 7. Standard of Diet

68. We have already stated that for patients the hospital catering service must provide a standard of feeding which is nutritionally sound and varied. This is equally necessary for staff. Hospital employees, however, are in the main a younger and more active age group. Moreover many are dependent on hospital meals for a considerable part of their working lives. It follows that they need more of the energy-giving foods than patients and a wider choice.

69. It was put before us in evidence that it is psychologically important that the meals for nursing staff should be different from the meals they have served to patients. But no difficulty should arise if both patients and staff have a choice of menu and in the case of staff they should be offered a wider choice than is practicable for patients.

Section 8. Dining-rooms and Service of Food

70. Out-of-date methods are still employed in the service of food to hospital staff. The tendency is towards a proliferation of separate dining-rooms (some of them very small) for separate categories of staff. These dining-rooms are frequently inconveniently placed so far as the kitchen is concerned; and waitress service is customary although sometimes inadequate. There are also some staff dining-rooms in which little or no attempt has been made to provide

attractive and restful surroundings and others which lack the necessary atmosphere of informality.

71. A modern hospital of any size is a complex organisation. And service of meals to staff at fixed times and during only a certain part of the day with a poor choice of menu, or no choice at all, is no longer justifiable. The aim should be a fast, flexible service offering a reasonably wide choice which would be available for staff delayed at meal times, staff going off duty early, staff returning late, staff returning at odd hours from leave and, above all, night staff for whom normal kitchen and dining-room facilities should be available.

72. Such a service can best be provided where staff dining-rooms are concentrated. Separate dining-rooms (each one in all probability with inadequate toilet and cloakroom facilities) for separate categories of staff cannot be defended.

73. The hospital service is one service and everyone employed in it belongs to the same team. A common staff dining-room (for all grades and for resident and non-resident staff alike), apart from its obvious advantages with regard to cost, saving of staff and flexibility of service, would give concrete embodiment to this truth and assist in the creation of a proper *esprit de corps*. A tendency to fragmentation is already very great in the hospital service and common staff dining-rooms would do something to counteract this tendency.

74. It has been put to us that separate dining-rooms for medical staff are desirable as they frequently wish to discuss cases over their meals and need privacy to do so. There are, however, other places where such confidential matters may be better discussed.

75. If it is accepted that resident and non-resident staff should have a common staff dining-room, the size of the dining-room will obviously have to be determined by the maximum number likely to use it at the busiest time of the day, i.e. lunch. A very large dining-room, however, is not very attractive for a small number and to provide a rather better atmosphere for the more limited needs of the residents at breakfast and supper we suggest that some part of the main dining-room should be capable of being partitioned off. Alternatively a smaller area could be permanently set aside complementary to the main dining-room. There should always be facilities (and issues of the necessary supplies) to enable resident staff, who are off duty and who wish it, to have light meals in their residences.

76. The provision of a single common staff dining-room is the ideal but it may not be practicable without major reconstruction in many existing hospitals. We recommend, however, that hospital authorities should move as quickly as possible towards the maximum practicable concentration of staff dining facilities in the interests of a better standard of catering.

Type of Service

77. So far as the type of service to be provided in the staff dining-room is concerned we recommend "self-service" for reasons of speed, flexibility and economy of service. When it is introduced care must be taken to achieve the highest standards.

78. In the evidence which we have received there were conflicting views about self-service. We believe that there is a good deal of psychological resistance to this type of service because it has so often been poorly done. The self-service system, however, is well established in hospitals in Canada and the U.S.A. and

in the newer hospitals of Europe. It has also been commended in the guidance on "Dining-rooms" contained in the Ministry of Health's Hospital Building Note No. 11.

79. The self-service restaurant should be so placed in relation to the kitchen that the kitchen staff are able to staff the servery. This has the additional merit of bringing the kitchen staff into direct contact with the consumers. There should be ample hot and cold counter space so that there is a minimum of queueing; and there ought to be satisfactory means of keeping food hot if the whole meal is to be uplifted at one time. The tables should be of good size and design. There must also be adequate facilities for the disposal of trays, etc., without noise or disturbance. Indeed noise must be guarded against in every way. The self-service counter itself should be screened off from the main dining area and full use should be made of acoustic tiling. Dining-room staff should have a sound knowledge of self-service methods, the proper handling of cutlery, etc. Self-service restaurants in hospitals are in the early stages of their development and a period of experimentation should be anticipated.

Ancillary Accommodation

80. Common staff dining-rooms by their very nature will have a large throughput of staff and should be provided with adequate ancillary accommodation such as cloakrooms. In particular, we consider adjoining lounges for coffee and smoking an integral part of the arrangements we have in mind. Lounges of this kind would not only afford valuable opportunities for relaxation but would increase the turnover in the dining-room and keep it free from tobacco smoke for staff who are just commencing their meal.

Sandwich Room

81. Although the common staff dining-room or self-service restaurant should be made available to all staff, there may always be a certain number of employees who might prefer to have a separate room where they can make tea and eat sandwiches which they have brought from home. Facilities of this kind should be made available.

Minimum Period for Lunch

82. The maximum benefit from this system of fairly quick meals with accommodation for relaxing afterwards cannot, in our view, be obtained in less than forty minutes. We would urge that all staff (and particularly nursing staff) should have at least this period for lunch.

Section 9. Payment for Meals

83. It has frequently been put to us in evidence that the present system of making a combined charge for board and lodging militates against the introduction of common staff dining-rooms with self-service arrangements so far as resident staff are concerned; and that the separation of the charge for meals from that for accommodation would facilitate a change of attitude.

84. We recommend that the present system of combining board and lodging charges for resident staff should be reviewed. Nurses, for example, who comprise the greater part of resident staff in a hospital now have more leisure time than

formerly and, as a consequence, are able to spend more time away from the hospital. But having to pay for meals outside hospital when on leave or pass inevitably seems to those affected to be paying twice. Apart from this consideration we believe that a system should be devised which would enable all staff—resident and non-resident—to pay for dishes which they wish to have rather than for a set three course meal. It would also enable those who wish to do so to pay more for more expensive dishes. As well as giving a wider choice to the staff the catering department would have more satisfaction in preparing a wider variety of dishes. We can think of no insuperable obstacle to the new approach which we have suggested. The payment for meals consumed can be achieved either through a ticket or voucher system or on the straightforward basis of payment at the end of the counter although a pay-desk is perhaps the greatest single deterent to fast moving traffic.

85. There is one exception that we reluctantly feel we must make to this recommended practice and that is in relation to resident student nurses. For this group of young people the hospital service is, in a sense, "in loco parentis". To remove any temptation to them to skimp on meals in order to have more spending money for other things we recommend that they be given "whole meal" vouchers on which there would be no rebate if the whole meal was not taken.

Section 10. Staff Catering Committees

86. Staff catering committees, we understand, have tended to function in practice mainly as sounding boards for grievances and complaints. The committees may well have formed quite a useful safety-valve. In our view a more effective day-to-day link between the kitchen and the consumer is the dining-room superviser provided that she has had proper training. Best of all, however, in our view, is regular and informal contact between the catering officer and the staff.

87. In the way that the catering officer should go out to the wards to see how his meals are being enjoyed by patients, equally he should visit the staff dining-rooms. If any members of staff feel that any aspect of the meals calls for criticism it is better for them and the catering officer for the grievance to be aired straightaway than for it to appear as an agenda item at some future catering committee meeting.

PART V

Purchase of Provisions

88. Efficient supply arrangements for provisions are essential not only because provisions account for more than one-third of the total bill for hospital supplies, but also because this category of supplies is one in which there are special difficulties in ensuring that satisfactory quality is being obtained.

89. Skilled ordering on the basis of pre-planned menus is the foundation of successful catering practice. It is sometimes claimed that the catering officer should have a free hand in the purchase of provisions. This raises difficult questions of control and accountability in a public service and we do not think that it can lead to the highest degree of efficiency. We favour the catering officer

being allowed to order under contract so far as possible—whether it is a contract for an individual hospital or group—or on regional or area contract.

90. Regional or area contracts are now well established. Difficulties have arisen, however, with regard to the optimum range of provisions to be included in such contracts; whether or not it should be obligatory on Boards of Management to participate in them; satisfying all the participants that a particular commodity is the best balance between price and quality; the duration and terms of contracts; and estimating requirements with reasonable accuracy.

91. The criticism most frequently expressed in regard to regional or area contracts is that they lead to the acceptance of the lowest offer irrespective of quality. It is also maintained that bargaining on such a large scale might ultimately limit competition; that it is not easy to check that what is supplied is the quality that is contracted for; and that a local hospital or group of hospitals might be inhibited from taking advantage of a bargain offer arising through stock clearance.

92. Some of the foregoing criticisms have of course a certain validity; but there is also, we think, a good deal of lingering prejudice and misunderstanding with regard to regional contracts. We have no hesitation in recommending that the system of regional or area contracting should be strengthened or extended. We do not take this view because such arrangements offer substantial economies, although this is a field in which the hospital service can undoubtedly gain some advantage from its size as reflected in its buying capacity. In our view regional contracts have even more important effects on standards, primarily because greater expertise is available under a properly organised system of central contracts.

93. In public buying, the acceptance of the lowest tender has frequently assumed over-riding importance. It is perhaps necessary now to emphasise the better standards that can be obtained by a system of large-scale contracting. So far as provisions are concerned, good quality is not only best for its own sake: it is best from the point of view of costs because of better results when cooking, etc., and because it facilitates better portion-control. Skilled purchasing is a question of considering quality in relation to price. We would like to see "value for money" replacing cheapness as the true criterion; and acceptance of the best rather than the lowest tender is surely desirable.

94. So that best use is made of all available expertise, regional catering advisers and catering officers should be fully consulted by the regional supplies officer. There should be standing committees of such officers in addition to Regional Boards' Supply Committees—and working parties or panels should be set up to agree specifications (where possible), to test samples of particular commodities and to advise on those most suitable for purchase. Full and frank consultation, however, is vital in arrangements of this kind. Regular meetings of supplies officers, catering officers and regional catering advisers can be productive of good results in many directions and their intrinsic value should be recognised. Visits to the premises of suppliers by such groups should also be encouraged.

95. The co-option of disinterested outside food experts to these Committees and to the working parties or panels would be of considerable help and we recommend that this practice should be resorted to more frequently than it is at present.

96. We also recommend that where regional contracts can be and are made, Boards of Management should participate in them even although individual

Boards consider that with some measure of freedom they might be able to make better *ad hoc* contracts through local initiative.

97. It has been known in the past, we understand, for the price secured under a regional contract to be made known locally and for some local supplier to offer to undercut this price. We strongly deprecate such a practice; not only is it unethical but no Board of Management can, in our view, always hope to get a good bargain by such means.

Scope of Regional Contracts

98. Regional or area contracts are well suited to the purchase of dry provisions and foodstuffs such as bread, meat and milk. It is also possible to contract for fish, potatoes and root vegetables. The position should be kept under constant review so that contractual arrangements may be extended or made more effective.

99. We are satisfied that national contracts for food have little to commend them, and there does not appear to be any need to widen the scope of contracting by combining Regional Boards for specific commodities. There are, however, some discrepancies in existing regional contracts which we consider would disappear if there were liaison from time to time between the supplies officers and catering advisers of the different regions.

100. So far as fruit, vegetables and possibly fish and certain other perishables of this kind are concerned, we do not favour catering officers buying in the market, even if this is convenient. There are difficulties inherent in controlling this type of buying and we prefer, and recommend, a system of weekly tenders from selected firms.

Length and Terms of Contracts

101. There is no uniformity at present in regional contracting on the length of time for which contracts for classes of provisions run. We doubt whether there is any need for regional uniformity in this matter. Indeed suppliers themselves have varying views on the optimum duration of contracts. Purchasing arrangements for a large region like the Western are not readily applicable to a smaller one like the Northern; and even within any one region there are large hospitals in closely knit groups and small hospitals widely dispersed in remote areas. Because of the many variable factors, contracting on a precisely uniform basis by Regional Hospital Boards or Boards of Management does not seem to be practicable. Much also depends on the nature of the commodities concerned. For example, a contract for flour, where fairly stable market and price conditions prevail, should normally be for a longer period than for bacon, where prices and quality are frequently susceptible to variations.

102. At present some contracts for provisions are on a firm price basis and others are on a retail price basis less a discount. We ourselves favour the firm price contract wherever it can be secured since it enables the hospital authority to budget with reasonable certainty for its catering service.

103. If high standards are to be obtained it is essential that the hospital service should avoid a reputation for hard or unfair bargaining. Confidence should be established between the hospital authorities and their suppliers. There should be firmness in the face of poor quality, unsatisfactory service or sharp practice. There should be some firmness too about the need for hospitals to estimate their requirements more precisely and to abide by their estimates so

far as possible. The aim should be to buy goods of the right quality at fair and reasonable prices obtained in open competitive tendering and to place fixed quantity contracts at firm prices for defined periods. There are always unforeseen factors but firm prices for fixed quantities or reasonably firm estimated quantities should be the aim; and we recommend that contracts should, so far as possible, be drawn up on this basis.

Checking and Storage

104. No contractual system will remain effective and vital unless there is an efficient system of checking supplies on delivery and a properly constructed store. Central stores, by permitting a concentration of staff and facilities at one point, are an advantage; and we recommend them provided that they are in other respects a viable proposition. Perishables constitute a special problem but, wherever possible, they should first be checked at the store before being sent to the kitchen. Kitchen staff should be trained in checking for quality and in cases of doubt assistance should be sought from any source of recognised authority, e.g., the appropriate Inspector of the Local Authority.

105. Correct storage, proper turnover, and rigid control of stock usage are essential. Proper ordering levels, adjusted as required for seasonal fluctuations, should be established and adhered to. Considerable improvement can, we believe, still be effected in regard to these matters.

106. We are unable to leave the question of supplies without drawing attention to the possibilities which exist in the hospital service for the creation of group butcheries and bakeries or for butcheries and bakeries serving several groups. Where suitable arrangements can be made, and there is frequently no reason why they should not be made, the production of better standards at lower cost will be materially assisted.

PART VI

Kitchens and Hygiene

107. Hospital kitchens have to meet complex demands. They should, therefore be planned along the most efficient lines and, by their very nature, they should be models of hygiene.

Section 11. Kitchens

108. In the course of our visits to hospitals we have, as a routine, inspected kitchen premises and discussed with kitchen staffs many questions relating to layout, equipment, training, etc. We have seen a cross sample of hospitals of different type, of different size, and of different age; and naturally the kitchen premises varied accordingly. Our main impression is that hospital kitchens have tended to come fairly late in the queue for improvements. The reason for this is not hard to guess. All hospital authorities have many schemes for improvement. Money for improvements has been perennially short. Consequently the schemes which generally have been accorded the highest priority are those which have directly contributed to the medical and nursing treatment of the

patients. Hospital kitchens being out of sight of the public eye and frequently able to function reasonably adequately in outmoded premises and with obsolete equipment have not had much hope of success in the competition for scarce funds.

109. We believe, however, that in many cases hospital authorities could effect substantial improvements from a not very substantial expenditure on their hospital kitchens. We have seen instances of outdated and inefficient equipment and also badly planned layouts which are wasteful of staff time. Moreover many hospital kitchens have quite inadequate ancillary accommodation, e.g. insufficient cold storage space, preparation areas and toilet and cloakroom facilities. We have also seen examples of new equipment having been bought without an adequate knowledge on the part of the purchasers as to the greater merits of alternative equipment.

110. To obviate a repetition of the mistakes of the past in relation to new hospital planning it was clear to us that hospital authorities were in need of detailed guidance in the planning and equipping of hospital kitchens. We are glad to note that such guidance has in fact recently been made available to hospital authorities in the shape of the Ministry of Health's Hospital Building Note No. 10. Because of this recent publication and the intention to supplement it by a Building Bulletin we do not think that there is any need on our part to give any separate detailed guidance. There are, however, certain broad points which we would like to make if we are to have conditions under which swift and easy production of a variety of menus from the kitchen is to be possible under present conditions of staff shortage.

111. First, we think that there need be only one central kitchen for up to approximately 1,500 mid-day meals. Where two or more kitchens are in existence in the one hospital to supply up to this number of meals we recommend that the position should be examined to ensure that the maximum concentration of facilities is achieved.

112. Secondly, the kitchen should be seen as part of a unified area embracing the stores and the serveries for the staff dining room. It should be designed on modern flow production lines. The planning should be open with separate functional departments within the main kitchen rather than separated off from it. Some rationalisation of existing kitchens as regards layout, etc., could, as we have said above, be achieved at no great expense. Most of the kitchens which we have seen have been deficient in modern equipment. If kitchens are to provide a choice of menu they will need some replanning with more items of smaller scale equipment than was customary in the past. We recommend accordingly that hospital authorities be asked to review their kitchen layouts and their needs for new equipment, and thereafter prepare schemes for consideration by their Regional Hospital Boards. In order to assist the hospital authorities concerned to make good at least the worst of any current deficiencies in their kitchens we would also recommend the Department of Health to extend for this purpose *ad hoc* financial allocations to Regional Boards.

113. In the third place, we would underline the fact that research is taking place at the present time into cooking equipment designed to cook on a more individual scale and also into equipment which will make rapid cooking possible. Such developments will facilitate the cooking of meals in relays (batch-cooking) and cut down handling and unnecessary pre-preparation of food. This research should be followed with close attention as it seems to us to be in line with future trends.

New methods

114. We have not made any exhaustive enquiries into new methods of food preparation or storage as we do not think that any of them are sufficiently developed to compete, economically and otherwise, with the conventional methods of large-scale catering required in the hospital service. Among the new methods we have in mind are the dehydration and deep freezing of food stuffs.

115. Some of us had the opportunity to visit the Experimental Research Station of the Ministry of Agriculture, Fisheries and Food in Aberdeen which has done some notable experimental work in the dehydration of food and developed a new method known as "accelerated freeze-drying". This process, we understand, is now to be developed commercially.

116. The deep freezing of all kinds of foods has already developed rapidly in the commercial world and has made available to householders a great range of cooked and packaged foods.

117. Following a recent survey in the south of England on behalf of the Nuffield Trust by a team under the leadership of Professor B. S. Platt, a revolutionary idea has been advanced that individual hospital kitchens should be replaced by central kitchens each of which would serve a large number of hospitals. First-class chefs, kitchen staff and caterers would prepare meals on a big scale under the best conditions; the prepared meals would then be deep-frozen as appropriate and stored against demand by the hospitals served from the centre.

118. Systems of this kind are currently in use by some large organisations, particularly air lines. In hospitals special facilities in the ward kitchen would be required to re-heat the prefabricated meals. We doubt whether this kind of revolutionary project is practicable at present particularly because of the food habits of the community. A stay in hospital is not the same as a journey by air; and we do not think that a complete diet of "convenience" foods would be accepted at the present time. If it became acceptable, it might well be more economical for hospitals to purchase processed or prefabricated meals direct from manufacturers than to set up an elaborate organisation within the hospital service to meet the need.

119. We are satisfied that "convenience" foods have a great potential value in the hospital service from the point of view of making a more varied diet possible throughout the year and also from the point of view of cost control. We think, therefore, that all hospitals should have deep freeze facilities. In addition, we consider it important that all of the developing methods of processing and preserving food should be kept under scrutiny as their application to hospitals may always be a possibility.

Central dishwashing and disposal of waste

120. Central tray service, to which we have earlier referred, involves central dishwashing. We are in any event in favour of central dishwashing. Existing buildings with their frequently awkward layouts make for difficulties, but central dishwashing in our view has the following substantial advantages:

1. It reduces noise in the ward area;
2. It reduces the non-nursing work to be carried out in the ward area;
3. By concentrating the washing up arrangements at one point, it facilitates mechanisation with consequent reduction in breakages, and enables the best use to be made of properly trained staff; and

4. It provides for routine sterilisation of all crockery and for higher standards of bygiene generally.

The washing up area sbould be separate from but convenient to the main kitchen. Washing up should be regarded as an important operation involving the use of properly trained staff, adequately supervised. Where complete centralisation is not possible it may be convenient to have common dish-washing facilties for groups of wards.

121. We also recommend that there should be an additional sink type unit in the washing up area in the bottom of which is a grinder within the waste outlet leading to the drain. All waste food matter returned to the kitchen and also kitchen swill sbould be placed in this unit and ground down and disposed of through the drain. Swill sbould be reduced to the minimum. We do not considcr tbat tbe income derived from it justifies the hospital service engaging in the unhygienic practice of collecting swill for sale.

Section 12. Hygiene

122. The attention of Scottish hospital authorities was drawn in July, 1959, to the provisions of the Food Hygiene (Scotland) Regulations, 1959. Tbese Regulations, which reflect an increasing public expectation of better food hygiene, impose standards on "food businesses". While the Regulations do not apply to Crown property and hospitals are accordingly not subject to their provisions, we arc glad to note that the Secretary of State for Scotland has asked hospital authorities to ensure that the standards of hygiene in hospitals are at least as rigorous as those imposed by the Regulations. Indeed, the highest possible standards should obtain in hospitals because of the extreme susceptibility of patients to all forms of infection and food poisoning.

123. A great deal of belpful and pertinent information about the need for and promotion of hygiene in all aspects of catering is contained in "Clean Catering" publisbcd by Her Majesty's Stationery Office. A furtber very useful booklet "Food Hygiene in Hospitals" was produced in February, 1959, by the Department of Health for Scotland. Accordingly we need refer only briefly to certain aspects of hygiene in bospital catering departments.

Responsibility for standards of hygiene

124. The catering officer should be aware tbat the immediate responsibility is his for securing the highest standards of bygiene practicable. Beyond this, however, we consider tbat there should be for each hospital a medical officer (e.g. the medical superintendent) with the designated duty of ensuring that the desired standards of hygiene are maintained. He should exercise his control in close co-operation witb the catering officer and tbrough the lay administrator where necessary.

Recruitment of staff

125. Satisfactory hygiene in the catering department should be one of the considerations in mind when recruiting catering staff. In matters of hygiene, education is preferable to compulsion and only staff of the necessary lcvel of intelligence sbould be engaged. All entrants should be medically examined before employment. The healtb of catering staff should be reviewed at yearly

intervals and they should be left in no doubt as to the need to report immediately to the head of the department any throat conditions, cuts, skin infections such as boils, or diarrhoea, etc.

Staff Cleanliness

126. Emphasis should continually be laid on the washing of hands, keeping the skin of the hands in good condition, and care of the nails. We advocate the use of paper towels rather than roller towels of any type; and we urge the banning of communal towels. Hand washing facilities must be provided at the working areas together with soap and nail-brushes. To prevent chapping, hand lotions should be available. We also consider that it would be a valuable aid to hygiene if paper handkerchiefs were supplied in hospital kitchens in place of personal handkerchiefs. Disposable paper or cellophane bags inside sanibins for used paper towels and handkerchiefs can be removed daily and destroyed.

Cloakroom accommodation

127. Cloakrooms, with individual metal lockers for hanging outdoor wear, safe keeping of handbags, etc., are necessary, as are toilet, hand washing and shower facilities. No outdoor clothing or bags should be allowed in the kitchen proper and if paper handkerchiefs are supplied staff should not be allowed to take their own handkerchiefs into the kitchen. Suitable protective clothing should be available for issue and outer aprons at least should be issued daily or more frequently if necessary. The hair of members of the kitchen staff should be completely covered.

Premises and equipment

128. Well lighted, well ventilated and easily cleaned surroundings are an incentive to more hygienic food handling practices. Walls and floors must be kept scrupulously clean and free from greasy deposit. Modern stainless steel equipment including tables, sinks, draining boards, etc., are easily kept clean and obsolete wooden furniture in hospital kitchens should be replaced as early as possible. Adequate cold storage accommodation is essential.

Washing up

129. As far as possible the washing of crockery and cutlery, as we have earlier recommended, should be done mechanically. Where washing is done manually the two-sink system should be used; the first sink for washing and cleaning and the second for sterilisation of crockery and cutlery. Crockery should be drain-dried and cutlery may be polished with paper towels.

130. Food trolleys should be returned to the central trolley wash as quickly as possible after the service of meals.

Education of staff

131. Continuous education of kitchen staff by example and precept should be reinforced by simple instruction in standards of personal and environmental hygiene and by talks aimed at underlining the importance of their work. Staff should be impressed with the fact that they are part, and a very important part, of the team dealing with patients.

132. We have stressed good hygiene practices because food poisoning is generally due to failure in this respect. The greatest single factor in the serving of clean food is the mental attitude of the staff involved. Good staff working with poor equipment in bad premises will be likely to achieve better standards of hygiene than poor staff working under ideal conditions. The introduction of improved equipment allowing for the more individual preparation of meals and of selective menus resulting in smaller-scale cooking, will help to kindle enthusiasm and interest. But good organisation and good staff management will always be the most important factors in developing and maintaining good morale. We turn now to organisation and staffing.

PART VII

Organisation and Staffing of the Catering Service

133. We have set high standards but they are worthwhile achieving if hospitals are to reflect, as we think they should, the general rise in the standard of living which is taking place throughout the country. High individual standards, however, depend upon skilful concentration of common services and facilities; and all the resources of a large-scale organisation are necessary. The hospital service is, of course, a large-scale organisation but its size can be exploited further. We have dealt with the specialisation and concentration of catering facilities within the hospital itself. But the catering services as a whole require to become at once more highly specialised and more closely integrated.

Section 13. Regional Catering Advisers

134. Most of the bodies we consulted were in favour of the appointment of regional catering advisers. The main doubts expressed about such appointments were the possible development of a uniform pattern in the catering service with a consequent loss of originality and variety in the catering at hospitals and, arising out of that, a reduction in the efficiency and initiative of catering officers. Some degree of uniformity and control is, however,necessary in a public service; and if the right appointments are made we think that the risks are slight and that the potential advantages are considerable. We, for our part, regard regional catering advisers as an essential link in the structure of the hospital catering service. The two largest Regional Hospital Boards already have catering advisers and we have no hesitation in recommending their appointment in all five regions. In catering, teaching by example is all important since it is a practical art as well as a matter of organisation and management. We consider, therefore, that the regional catering adviser should continue to be engaged in practical catering. No special arrangements may be necessary to achieve this in the smaller regions where such an appointment might well have to be combined with a catering officer appointment. In the larger regions, however, we suggest that the catering adviser should have access to a working kitchen. We also recommend that the regional catering adviser should have extra staff available to enable him to carry out training activities and to assist in implementing at other hospitals in the region any proposed improvements.

Regional catering advisers will, in our view, help to integrate the service so that it may derive some of the advantages which go with size instead of some of the disadvantages as sometimes seems to be the case. But they should not simply be experts who are available when wanted by Boards of Management: they should have a positive role.

135. We envisage that regional catering advisers would have the following duties:

(1) Advising Regional Hospital Boards and Boards of Management on capital schemes including major reorganisation or provision of kitchens.
(2) Advising on catering equipment and plant generally.
(3) Advising on problems of small hospitals which do not themselves have catering officers.
(4) Investigating above and below average costs and advising on appropriate action.
(5) Keeping abreast of new developments and bringing these to the notice of catering staff in the region.
(6) Improving standards of food preparation, serving and organisation, by visitations and surveys, demonstrations and courses.
(7) Advising Boards of Management in connection with the appointment of catering officers.
(8) Advising on purchasing of provisions.
(9) Meeting regularly with catering officers in their own regions and with catering advisers in other regions.

136. In recommending the appointment of regional catering advisers we do not discount the employment of outside consultants on an *ad hoc* basis: but we do not think that there is a satisfactory substitute for constant interchange of views and advice between different levels of the service. This can only be achieved by officers who are themselves employed by the hospital authorities.

Qualifications of Regional Catering Advisers

137. To undertake effectively the range of duties that we consider appropriate to a catering adviser it will be necessary to recruit individuals of outstanding ability, wide experience and (most important) good personality. As part of the work of the catering adviser is to point out to other catering staff how to improve performance, it follows that the adviser has not only himself to have the expertise but that he must be able to impart his knowledge to others with tact. Catering officers already employed in the hospital service might well, if suitable, be appointed to these posts, and such an avenue of promotion would encourage the staff employed in the catering field. At the present time, however, we do not think it essential for a catering adviser to have had hospital experience before his appointment; provided that he has had good hotel training and experience or suitable training and experience in some other sphere and has the right personal qualities, it would be possible for him, in our view, to be given a short concentrated course on the hospital aspects of catering before undertaking duties in his region.

138. In our view the salary scales for regional catering advisers must be such as to attract persons of the calibre who would make a real impact on the hospital catering service. We do not think that this will be achieved by trying to

recruit regional catering advisers at salaries only marginally above those paid to catering officers. Unless the right appointments are made—and the right range of salary has to be offered to attract the right people—regional catering advisers will inevitably not be held in esteem by the catering departments of hospitals; and the potential benefits of the appointment will be lost as well as the salaries actually paid wasted. In short, we see this as a potentially worthwhile service which could do untold good if properly organised but which could equally engender disharmony, and indeed prejudice the catering services, if mismanaged.

Section 14. Catering Officers

139. Within the individual hospital of reasonable size (serving at least 350 mid-day meals), the creation of a specialised catering department under the control of an experienced catering officer is the indispensable minimum if proper professional standards are to be obtained. The catering officer should be responsible for all activities relating to the production of meals, including menu-planning, ordering under contract, and dining-room service. His responsibilities must be clearly understood. Only if his department is under his control will he be able to extract the maximum efficiency from it. Where the situation has not been clarified along the above lines we recommend its early clarification. The responsibilities of the dietitian and of the medical and nursing staff in regard to the catering services are dealt with later in our Report.

140. The smaller hospitals should be able to obtain the services of an expert catering officer and we recommend the appointment of group catering officers where this has not already been done, or, if more appropriate, the appointment of catering officers with advisory duties in neighbouring small hospitals. Large hospitals may find it useful in addition to appoint assistant catering officers.

141. The catering officer should have a background of large-scale catering experience. We do not support the proposal put forward by the King Edward Fund for catering manager posts as distinct from catering officer posts. Where a catering officer *is* justified, he should be given the full range of responsibility for the catering department.

Outside Firms

142. A few hospitals in Britain have attempted to solve their problems by farming the catering service out to private firms. This course does not commend itself to us. We doubt if it is ever a satisfactory solution to the problems of the individual hospitals which have resorted to it. In our view hospitals should be able to run their own catering services and they will not be on a proper footing until they can do so with reasonable efficiency.

Section 15. Administrative and Financial Control

143. Because of their great impact on patients and staff, the catering services should be subject to regular review in the same way as the medical and nursing services. Regional Boards and Boards of Management should have catering committees or sub-committees to ensure that such regular review takes place.

144. Budgetary and cost control as applicable to the catering department seems capable of improvement. We would recommend that, as a minimum, catering officers should be informed of the financial allocation for their depart-

ment. They should also be kept informed as soon as the information can be made available and at monthly intervals throughout the year of the budgetary position and of the cost per person fed broken down, where practicable, into different categories of provisions. A form suitable for this purpose is shown in Appendix F.

145. Food costs are still the basis of costing in the catering department. There are some difficulties in relying on food costs alone. The initial cost of some items may be low but they may be expensive to prepare. Departmental costing has not yet produced information in sufficient detail to enable much use to be made of it in the catering department. We think it should be possible for production, service and provision costs to be determined in relation to a proper standard of diet; and we hope that steps will be taken in this direction and also in the direction of establishing staffing ratios in relation to production and service. It should also be possible to establish as a broad guide the quantities of different foods which should be provided in different categories of hospital.

146. We think it is possible that the "watch-dog" aspect of financial control has been over-emphasised. This has led to some misunderstanding between catering officers and their Boards. It is now generally understood that financial control is an indispensable aid to effective management. Financial information should be provided as a service to catering officers upon which they come to rely for essential guidance.

Section 16. Recruitment of Staff

147. The shortage of trained catering staff and the rate of turnover of staff are two of the major problems at present confronting hospitals. These difficulties in a large service department like the catering department can, to some extent, be overcome by concentration of facilities in the ways we have indicated and by improved methods of work. In our view there is considerable scope for work study in the catering department. But no matter how efficiently planned an organisation is, it cannot be more efficient than the staff who serve it. Adequate training arrangements of the kind we recommend later in our Report will help towards this end; but it is equally important to consider how catering staff are to be attracted to the hospital service and retained by it.

148. In the past, hospital catering staff tended to have little or no status, and, even if that no longer holds good, it is still the case that insufficient attention is being given to the need for providing in the hospital service a really attractive career for well trained catering staff. Hospitals are no longer charitable institutions; they are among the country's most important social services. In the variety and complexity of the problems which the hospital service produces, there is a challenge, the magnitude of which is not always appreciated. This is true of the catering department as of any other department in a modern hospital.

149. Our impression is that the remuneration and conditions of service of senior catering staff are not sufficiently competitive. We appreciate that in a public service there are difficulties about applying too literally the criterion of "fair comparisons"; and the public service has its own rewards to offer to the person who is interested in a socially rewarding job. But in our view, there must be some attempt at "fair comparisons" if catering experts of sufficient calibre are to be attracted to hospitals.

150. Supervisory staff such as dining-room supervisors and particularly kitchen superintendents require special recognition. The kitchen superintendent

(or head chef) should be something more than a first among equals in the kitchen. In the highly specialised semi-commercial kitchen which is more and more being seen in hospitals his duties are in the sphere of management. This should be recognised both in terms of remuneration and conditions of service.

151. We recommend accordingly a review of the salaries and wages structure of the hospital catering service by the appropriate authorities. A new picture of hospitals is gradually taking the place of the old in the public mind, and given a solution to the remuneration problems we are sure that the hospital service could offer a really attractive career for first-class catering staff.

Conditions of work

152. The conditions under which catering staff work also need substantial improvement. We have already drawn attention to the need for staff cloakrooms. Kitchens should not only be functional; they should, so far as possible, be pleasant places to work in. Proper clothing should be supplied. New members of staff should be properly initiated into the department and they ought to be given some idea of how the hospital as a whole is organised. In short, catering staff matter; and they should be made to feel that they matter. This is particularly necessary in view of wrong attitudes in the past.

Section 17. Training and Career Structure

153. The expenditure on purchase of provisions alone amounted to some £4,500,000 in 1960/61 or approximately 10 per cent. of the total hospital running costs for that year. There are also over 4,000 persons employed in one way or another in the catering services of Scottish hospitals. Taking these factors together it might be expected that some systematic training for catering staff would be in force to ensure that, grade for grade, the hospital catering service was as efficiently manned as possible and giving the maximum return for the considerable expenditure involved. We find, however, that in this, as in other aspects, the catering service has been accorded a low priority, both in terms of consideration and of money for improvement. It is not too harsh a judgment in our view to say that up till now the training of catering staff has been haphazard rather than systematic. Our impression is that this contributes to the high rate of turnover of staff.

154. The only formal training which currently exists is the Apprenticeship Scheme for Cooks in Hospitals. This Scheme has operated since 1954 but has been only moderately successful: no more than 18 hospitals are currently participating in the Scheme. Among the difficulties which have been encountered is the securing of suitably trained personnel to train the apprentice cooks and suitable kitchens for training purposes.

155. There are in addition certain facilities for day release to a number of local education authority schools providing training for the catering trade; and certain *ad hoc* training has been undertaken by the South-Eastern Regional Hospital Board's Catering Adviser at the Royal Edinburgh Mental Hospital.

156. In our view training of staff in such a large and extensive service as the hospital catering service should not be so left to chance. Organised training at the centre and in each region should we think take the place of present dependence on local initiative.

Central Training School

157. We recommend the establishment of a central training school for hospital catering staff which would preferably be associated closely with an existing major hospital. Among the advantages of such an arrangement are that trainees would be able to see catering for a hospital being carried out in an exemplary way and could themselves undertake practical work in the hospital kitchen under trained supervision.

158. Some of us visited the King Edward's Hospital Fund for London School of Hospital Catering and were much impressed by the quality and range of instruction given there. We consider that a Scottish school providing such a service would be of inestimable value to the Scottish hospital service.

159. The provision of a full range of courses and refresher courses for senior catering staff and trainee catering officers should be the primary function of the central school. It could also undertake specialist instruction in nutrition and in such matters as butchery, pastry and cake making. In addition special courses for nursing staff in charge of catering at small hospitals would be of value.

160. The establishment of a comprehensive central school adequately equipped and staffed and preferably with residential accommodation for trainees will clearly require considerable funds. This must be recognised and allowed for if worthwhile training facilities are to be set up.

Regional Training

161. It should be part of the functions of each regional catering adviser to organise at an appropriate hospital or hospitals in his reg on courses of training and refresher courses for cooks, assistant cooks and other junior staff which would be complementary to the courses provided for senior staff at the central school.

162. Training of this kind at the regional level will be necessary to achieve and to maintain improved standards. We recognise that it will not always be easy for the smaller hospitals to release staff for such courses but, as it is in their own interests, we recommend that they do so. Hospital authorities should try to facilitate release by authorising temporary appointments or affording temporary assistance from the larger hospitals.

Local Training

163. There will always be a need for training cooks at hospital level. With a greater number of well qualified cooks and head cooks in the hospital catering service it should be possible, for example, to develop the present Apprenticeship Scheme for Cooks along more satisfactory lines.

Training in general

164. In summary, as we see it, therefore, the Scottish hospital catering service urgently needs properly organised training arrangements of the kind we have recommended above. The size of the country and the number of employees in the hospital catering service make a well-co-ordinated national scheme feasible. Existing outside institutions could not provide the necessary specialised facilities or instruction although use might be made of the services of staff from such outside institutions. It would also be desirable to employ for instructional purposes recognised experts from the catering industry.

165. Good training arrangements are essential in the interest of improved standards of skill and efficiency. They will give staff a greater degree of satisfaction from their work and develop to the full their potential ability. In combination with skilful selection they will secure the succession to senior posts. To be successful, training will require to be dynamic and not merely a return to the schoolroom. Many of the suggestions contained in this Report mean breaking away from traditional methods, but new and better methods will only be adopted where staff have been consciously trained in them.

Career Structure

166. There are difficulties in the way of providing a proper career structure for catering staff in the hospital service. The service is not centralised but is split up into a great number of different employing authorities. While we have no wish to see the autonomy of Boards of Management encroached upon we consider it essential that expert technical advice is available when senior catering staff are selected. To this end we recommend that the regional catering adviser should be present as assessor at all appointments of catering officers and assistant catering officers in his region. Similarly the Department's catering adviser should be present at all appointments in Scotland of regional catering advisers and their deputies.

PART VIII

Role of Other Staff

167. It is important to bear in mind that doctors, nurses and dietitians are also concerned with the catering services. The dietitian should have advisory functions in relation to the general catering services in addition to her functions in regard to therapeutic diets. So far as medical and nursing staff are concerned we consider that they play more than "an important advisory part".* They are responsible for satisfying themselves that the nutritional needs of patients and staff are being met. This does not mean that doctors and nurses have any administrative responsibility for the catering services; but it does mean that they must take a sustained and critical interest in the performance of the catering department. All medical and nursing staff ought, in our view, to have some practical knowledge of the working of the catering department.

Section 18. Doctors

168. As proper food is an essential part of medical treatment the final responsibility for the nutrition of the patient rests with the doctor in charge of the case. We deal accordingly first with the need for education and training of doctors in questions of nutrition.

169. Opportunely a Report has recently been published of a Joint Food Agricultural Organisation/World Health Organisation Symposium on Education and Training in Nutrition in Europe which took place at Bad Homburg in December, 1959. We need do no more in the circumstances than quote the

* Report on the Internal Administration of Hospitals, 1954.

following extracts from this interesting and authoritative Report.

> "The doctor needs more than a theoretical knowledge of calories, proteins, minerals and vitamins. . . . He needs to know how . . . to advise his patients correctly about what to eat when they are sick. He must also know how to instruct dietitians, nurses and housewives about the feeding of healthy and sick people".
>
> "The Symposium discussed thoroughly the present status of the training of medical students in nutrition. It was made clear that such training is inadequate in many medical colleges and schools. Though many of the physiological, biochemical and clinical aspects of the subject are taught, what is taught through the various disciplines is not 'integrated' into a whole. Further, the subject is not presented in relation to the practical every day problems of family life. In order to remedy this state of affairs, one person with a comprehensive and practical knowledge of nutrition could with advantage be made responsible for co-ordinating and supplementing the various aspects of nutrition teaching at all stages of the medical student's curriculum".

170. We hope that the medical schools of this country will give due consideration to these recommendations. We, for our part, suggest that it would be of assistance both to medical staff in hospitals and to general medical practitioners if, during their training, they could in addition be given adequate instructions on the basic nutrient composition of special therapeutic diets.

Section 19. Nurses

171. The majority of patients in Scottish hospitals do not require controlled therapeutic diets, but their meals often need adjustment according to their progress, treatment, appetite, activity, etc. The proper feeding of the patient, is, therefore, a highly individual matter and must, as we have already emphasised, be under the immediate control of the ward sister and her nursing staff.

172. A corollary of this concept is that their training should provide nursing staff with a sound understanding of the practical implications for patients' treatment of the theory of nutrition. The Report of the FAO/WHO Symposium, referred to in paragraph 169 above, states that

> "The instruction of nurses in nutrition and the co-ordination of teaching in this field generally should be the responsibility of one person with special qualifications in the subject. This person should be a participating member of the teaching staff of the school of nursing and be supported in teaching activities by nutritionists, dietitians, and physicians".

173. A number of special courses are already provided, including "refresher" courses for ward sisters and trainee courses for nurse tutors and matrons. Adequate instruction in nutrition and dietetics is essential in all these courses. All senior post-registrational courses should include some instruction in catering and kitchen techniques.

Section 20. Dietitians

174. We are in no doubt that the dietitian has an important part to play in the therapeutic service of a modern hospital. Frequently the proper function of

dietitians is not adequately appreciated by medical, nursing and catering staff. The practice of dietetics as a profession is, of course, relatively young and is still developing.

175. Special diet kitchens were opened for the first time in Scotland in the Royal Infirmaries of Edinburgh and Glasgow about 35 years ago. Nurses and science graduates were soon accepted for training. Ten years later the British Dietetic Association was formed and since that time it has been the accepted body for representing and promoting the dietetic profession. The Association at present has over 700 members. Less than half of this number appear to be employed in hospitals.

176. The Cope Committee which considered the duties of dietitians stated in 1951:

> ". . . trained dietitians are needed in hospitals to undertake *inter alia* the following duties:
>
> (1) The preparation of special diets in hospitals according to doctors' prescriptions.
>
> (2) The giving of advice concerning the nutritive value hospital diets to those caterers who have no special training in nutrition.
>
> (3) The giving of advice to out-patients aud of lectures and demonstration to nurses, student dietitians and medical students, on the subject of therapeutic and normal diet".

177. A recently published survey conducted jointly by the Ministry of Health and King Edward's Hospital Fund for London shows that these aims are only partly fulfilled in England and Wales at the present time. The same is generally true in Scotland. Because we attach importance to the role of the dietitian we think it is a matter for concern that there is so great a shortage in Scottish hospitals at the present time. In estimating the shortage we have taken account of the fact that although the number of therapeutic diets dispensed in general hospitals should be small (10%—15%) in relation to the total number of meals served, the care and attention needed in their preparation makes it difficult for one dietitian—even with adequate subordinate staff in the diet kitchen—to supervise more than thirty therapeutic diets daily. On this basis, and taking account only of the average number of patients in Scottish general hospitals, we estimate that between 70 and 100 dietitians should be employed in hospital practice in Scotland. Against this requirement there are only some 50 dietitians employed in Scottish hospitals at the present time. On these figures the hospital service in Scotland is at present employing only about half thc desirable complement of dietitians.

178. Even if they wished to, hospital authorities could not quickly increasc their establishment of dietitians. There are not enough trained people for the posts currently advertised. The British Dietetic Association reported in 1959 that 112 hospital posts in the United Kingdom were unfilled. One professor at a Scottish teaching hospital (which at present has no dietitian) drew our attention to "the unsatisfactory position which arises when hospital authorities can be discouraged from making necessary and valuable appointments of dietitians because of the widespread shortage of suitable individuals for the posts".

179. We are satisfied that many members of the British Dietetic Association find it more interesting or profitable to seek employment outside the National Health Service, e.g., in teaching, research, industry, school meals service.

Hours and working conditions are also frequently better in such outside employments.

180. The salary scales and promotion prospects of dietitians in the hospital service are not commensurate with the lengthy and costly training that the great majority of the recruits undertake. Could the same basic standards be achieved with a shorter training? At present recruits are normally required to have one of the following prior qualifications: S.R.N., B.Sc., Domestic Science Teachers' Diploma, Institutional Management Diploma. They follow a course in dietetics lasting usually one year, followed by six months practical training in a hospital. The normal training period is therefore four to four-and-a-half years from the time of leaving school. In the circumstances it seems to us that further consideration might be given to the training syllabus and pre-entry requirements by the appropriate authorities against the background of a need to attract more deititians to the hospital service. At the same time, however, we appreciate the need to maintain standards and preserve the status of the dietitian.

181. It may be that additional training centres are necessary. At present there is only one institution—the Glasgow and West of Scotland Domestic Science College—providing a course in dietetics in Scotland. The course formerly provided by Edinburgh Royal Infirmary ceased in 1956 although this hospital continues to provide practical training for students from Glasgow and elsewhere during the last part of their course. We would suggest that consideration might be given to the opening of additional training centres.

182. In order to overcome the problems created by the shortage of dietitians, we make the following recommendations:

(1) More general provision of training grants to offset the expense of training.

(2) A review by hospital authorities of the dietetic services at present provided to ensure that hospital authorities themselves have a clear understanding of the scope of the specialist service that a dietitian can give; that the dietitian has adequate facilities and staff to enable her to do her work properly; and that she obtains necessary co-operation from medical, nursing and catering staff.

(3) We have already recommended (paragraph 39) the creation of group dietitian posts. We would also like to see consideration given to the creation of a new grade of dietetic assistant. We are impressed by the arguments put forward at the FAO/WHO Symposium already referred to, in regard to the need for an auxiliary in this field. Many of the more routine tasks can be carried out by personnel who have had less advanced training than the qualified dietitian. By relieving the dietitian of routine tasks, the auxiliary worker would set her free for therapeutic duties. In this way both a better quality of service and a greater coverage should be assured. Standards will be maintained and improved, and the dietetic service extended. There might also be advantage in this context in giving formal recognition to a grade of diet cook, since many dietitians may be burdened with cooking duties.

PART IX

Central Planning and Control

183. Before concluding our Report we would like to underline the importance we attach to the part which can be played in the improvement of the hospital catering service by the Department of Health and the Regional Hospital Boards. In view of the technical developments which are taking place in catering, we envisage the role of the Department and of the Regional Boards as one of increasing importance. Personnel engaged in day-to-day management are not always able to initiate fundamental changes. Leadership from the Department and the Regional Boards, particularly in regard to research and to the dissemination of information and ideas, would be invaluable.

184. We have dealt at length in our Report with the main issues that seemed to derive from our remit. We have also drawn attention to some aspects of hospital catering that require more detailed investigation and others that need to be kept under constant review. We would suggest that further examination of this kind could most appropriately be undertaken by a standing committee of senior officers of the hospital service representative of various aspects of catering services.

185. A summary of our main conclusions and recommendations follows.

PART X

Summary of Main Conclusions and Recommendations

General

(1) The appointment of experienced catering officers has eliminated many of the less attractive features of institutional catering; patients and staff are, on the whole, provided with a reasonable dietary but there are still deficiencies and short comings in the catering services (paragraphs 8 and 9).

(2) Hospitals should set nutritional standards capable of having an educational influence on the community (paragraph 11).

(3) More attention should be paid to the individual nutritional requirements of patients and staff (paragraphs 12 and 13).

Nutritional requirements of patients

(4) The essential aim should be to give every patient acceptable meals, to make good any previous dietary deficiencies and to provide for current nutritional needs (paragraph 15).

(5) Uniform nutritional standards against which definite quantities of different foods might be purchased are not practicable. Hospital catering should aim at being as flexible as possible using nutritional standards as a guide, (paragraphs 19 and 20).

(6) Menus for hospitals should be planned in relation to the average caloric requirement of different categories of patients. Sufficient fruit and vegetables should be included in all hospital menus (paragraph 21).

(7) The standard of dietary provided for patients in mental and mental deficiency hospitals should be improved as should catering facilities generally in these hospitals (paragraph 25).
(8) Only 10 to 15 per cent of patients in a general hospital require controlled therapeutic diets (hospitals providing more than this proportion should critically examine their practice) (paragraph 32).
(9) The diet kitchen should be a separate bay within the main kitchen or be adjacent to it so that maximum integration may be achieved (paragraph 33).
(10) The dietitian should regularly visit patients on therapeutic diets; effective liaison between the dietitian and medical, nursing and catering staff is essential (paragraphs 36 and 37).
(11) A full-time dietitian can be usefully employed in any hospital dealing with acute cases of 150 beds or over. For other hospitals a group dietitian should be available (paragraphs 38 and 39).

Service of food to patients

(12) A choice of menu should be offered to patients; selective menus based on, say, a six weeks rota should be the aim (paragraphs 41 and 42).
(13) To provide some control over standards, sample selective menus suitable for hospital use should be issued at intervals (paragraph 43).
(14) A central tray service at selected hospitals should be installed on an experimental basis (paragraph 52).
(15) Main meals should be served at the following times—Breakfast between 7 and 8; Lunch between 12 and 1; and Supper not earlier than 6 (paragraph 55).
(16) Nursing staff should continue to supervise the service of meals whether the food is brought in bulk to the ward or it is distributed by means of a central tray service. The actual service to the patient, however, might with advantage be undertaken by other trained ward staff (paragraph 56).
(17) Medical staff should pay periodic informal visits to the ward at meal times to see that the catering department is meeting the nutritional requirements of patients (paragraph 58).
(18) Proper dining facilities should be provided for ambulant patients (paragraphs 59 and 60).
(19) The bringing in to patients of substantial gifts of food and beverages should be discouraged (paragraphs 61 and 62).

Catering for staff

(20) Staff will generally require more of the energy-giving foods and a wider choice than patients (paragraph 68).
(21) A single well designed and furnished "self-service" restaurant, catering for all grades of staff and providing a fast flexible service, should be the aim (paragraphs 73, 77 and 79).
(22) The system of combining board and lodging charges for resident staff should be reviewed so that all staff (with the exception of student nurses) can pay directly for meals (paragraphs 84 and 85).

Purchase of provisions

(23) Regional or area contracts should be extended (paragraph 92).

(24) Value for money and not the lowest price should be the criterion in accepting tenders. Fixed price contracts for firm quantities or reasonably firm estimates of quantities for fixed periods are to be preferred, and so far as possible contracts should be negotiated on this basis (paragraphs 93 and 103).
(25) Working parties or panels should be established to agree to specifications, to test samples of particular commodities and to advise on those most suitable for purchase (paragraph 94).
(26) Boards of Management should participate in regional contracts (paragraph 96).
(27) Consideration should be given to the establishment of group butcheries and bakeries (paragraph 106).

Kitchens and hygiene

(28) Hospital authorities should review their kitchen layouts and needs for new equipment; and they should be given funds to make good the worst of present deficiencies (paragraph 112).
(29) Research into equipment designed for better and more individual methods of cooking should be encouraged (paragraph 113).
(30) "Convenience" foods can make a more varied diet possible throughout the year and all hospitals should for this purpose have deep freeze facilities (paragraph 119).
(31) Central dishwashing has advantages over ward cleaning of crockery and cutlery (paragraph 120).
(32) Swill should be reduced to the minimum and hospital authorities should cease to retain it for sale (paragraph 121).
(33) Satisfactory hygiene in the catering department should be borne in mind when recruiting and training staff. Facilities for encouraging the promotion of hygiene should be provided and a medical officer should be responsible for ensuring that the desired standards are obtained (paragraphs 125-132).

Organisation and staffing of the catering service

(34) Regional catering advisers should be appointed by all five Regional Hospital Boards in Scotland (paragraph 134).
(35) The catering department of any hospital serving at least 350 mid-day meals should be under the control of a catering officer. Smaller hospitals should have the services of a group catering officer (paragraphs 139 and 140).
(36) Hospital authorities should review their catering services regularly (paragraph 143).
(37) Budgetary and cost control should be developed for the catering department (paragraph 144-146).
(38) A review of the salaries and wages structure of the hospital catering service with particular reference to senior catering staff should be undertaken (paragraphs 149-151).
(39) A central training school (supplemented by regional and local training) should be established for hospital catering staff (paragraphs 157-163).

Role of other staff

(40) The training of medical students should include adequate instruction in nutrition (paragraphs 169-170).

(41) Nursing staff during training should be provided with a sound understanding of the practical implications for patients' treatment of the theory of nutrition (paragraph 172).

(42) The hospital service needs more dietitians. A review of training arrangements should be instituted (paragraphs 180 and 181).

(43) Hospital authorities should review their existing dietetic services; and consideration should be given to the creation of new grades of dietetic assistant and diet cook (paragraph 182).

Central planning and control

(44) Leadership from the Department of Health and from the Regional Hospital Boards particularly in regard to research and dissemination of information would assist in the improvement of the hospital catering service (paragraph 183).

(45) A standing committee of senior officers of the hospital service should be set up to investigate and keep under review new developments in hospital catering (paragraph 184).

We desire to thank the many organisations, authorities and individuals who, by the submission of evidence, by participating in discussions, by enabling us to undertake comprehensive and most useful visitations to hospitals and institutions, and in many other ways, made our task so interesting.

Shortly before the final revisal of this Report, the Committee suffered a very severe loss by the tragic death of one of their number, Dr. A. P. Meiklejohn, to whom they were deeply indebted for a very considerable amount of material and valuable advice, particularly in connection with nutritional values and the medical requirements of patients and staff.

Finally, we desire to record our great appreciation of the assistance which we have received from Mr. Fair and Dr. Inch as Joint Secretaries, and from Mr. Godfrey, Miss Macpherson and Miss Robinson as Observers. We are particularly indebted to Mr. Fair to whom has fallen the difficult task of recording many views and of preparing drafts of the Report following discussions which covered a very large number of topics.

CHARLES S. GUMLEY,
Chairman
(on behalf of the Joint Committee.)

31*st July*, 1961.

APPENDIX A

Written Evidence

Association of Scottish Hospital Boards of Management.
Association of Scottish Hospital Matrons.
British Medical Association—Scottish Council.
Eastern Regional Hospital Board.
General Board of Control for Scotland.
Hospital Caterers Association—Scottish Branch.
Institute of Hospital Administrators—Scottish Division.
King Edward's Hospital Fund for London—Hospital Catering and Diet Committee.
Northern Regional Hospital Board.
North-Eastern Regional Hospital Board.
Royal College of Nursing—Scottish Board.
Scottish Association of Medical Administrators.
Western Regional Hospital Board.

APPENDIX B

Oral Evidence

Mr. R. Barton, Co-ordinatiog Officer for Supplies, South-Eastern Regional Hospital Board.
Miss J. Butchart, School of Domestic Science, Robert Gordon's Technical College, Aberdeen.
Professor Robert Cruickshank, Department of Bacteriology, Edinburgh University.
Miss L. Currie, Glasgow and West of Scotland College of Domestic Science.
Major W. J. Dixon, Command Catering Adviser, Scottish Command.
Dr. A. M. Fraser, Senior Administrative Medical Officer and Secretary, Northern Regional Hospital Board.
Miss S. J. Guy, Miss J. Inglis, Miss R. E. Longstaff, and Miss K. Rose, British Dietetic Association.
Mr. I. B. Henderson, Chairman, Scottish Branch of Hospital Caterers Association.
Mr. J. H. Livingstone, Deputy Secretary, and Mr. A. M'Donald, Contracts Officer, Western Regional Hospital Board.
Miss E. M'Laren, Miss M. F. Miller, and Miss M. H. S. Hunter, Royal College of Nursing (Scottish Board).
Mr. R. Moore, Secretary, Eastern Regional Hospital Board.
Miss H. J. S. Sandison, Edinburgh College of Domestic Science.
Dr. J. B. Stolte, Physician Superintendent, St. Elizabeth's Hospital, Tilburg, Netherlands.
Mr. G. J. Stormont, King Edward's Hospital Fund for London—Hospital Catering and Diet Committee.

APPENDIX C

Visits to Hospitals and other Establishments

Aberdeen Maternity Hospital, Aberdeen.
Aberdeen Royal Infirmary, Aberdeen.
Army Catering Corps Training Centre, Aldershot.
Astley Ainslie Hospital, Edinburgh.
Ayr County Hospital, Ayr.
Belford Hospital, Fort William.
Craig Dunain Mental Hospital, Inverness.
Dundee Royal Infirmary, Dundee.
Dundee Royal Mental Hospital, Liff.
East Fortune Hospital, East Fortune.
Eastern General Hospital, Edinburgh.
Edinburgh Royal Infirmary, Edinburgh.
Galashiels Hospital, Galashiels.
Gogarburn Mental Deficiency Institution, Edinburgh.
Glasgow Royal Infirmary, Glasgow.
Heathfield Hospital, Ayr.
King Edward's Hospital Fund for London—School of Hospital Catering, St. Pancras Hospital, London.
Kingseat Mental Hospital, Newmachar.
Maryfield Hospital, Dundee.
Marks and Spencer Limited, London.
Ministry of Agriculture, Fisheries and Food Experimental Factory and Research Establishment, Aberdeen.
Peel Hospital, Clovenfords.
Raigmore Hospital, Inverness.
Roodlands General Hospital, Haddington.
Royal Edinburgh Mental Hospital, Edinburgh.
Royal Hampshire County Hospital, Winchester, Hants.
Royal Northern Infirmary, Inverness.
St. Thomas's Hospital, London.
Seafield Sick Children's Hospital, Ayr.
Southern General Hospital, Glasgow.
Stracathro Hospital, Brechin.
Stratheden Mental Hospital, Springfield, Cupar.
The Cottage Hospital, Campbeltown.
The Queen Alexandra Military Hospital, Millbank, London.
Vale of Leven Hospital, Alexandria.
Witchburn House, Campbeltown.

APPENDIX D

Therapeutic Diets

A Memorandum by Dr. A. P. Meiklejohn

While it is probable that the majority of patients treated in British hospitals need no special diets, there are nevertheless a number of disorders in which dietary measures have undoubted therapeutic value and should be a regular part of treatment. Some of these disorders are listed below, together with the type of diet needed for each.

The amount of care and precision required in prescribing and dispensing these diets obviously depends very much on the nature of the disorder and its severity. To give some indication of this, the diets listed below are labelled A, AB or ABC on the following basis:

A. *Qualitative regulation:* Directions are needed on the foods to give and/or foods to withhold.

B. *Quantitative regulation:* The *amounts* permitted of certain foods should be prescribed in terms of kitchen measures.

C. *Precise quantitative regulation:* The full therapeutic value of the diet can only be achieved by *weighing* certain individual items of the foods as served.

Disorders	*Diets needed*	A (do's & dont's)	B (measured amounts)	C (weighing needed)
Diabetes Mellitus	restricted carbohydrate	A	B	(C)*
Digestive disorders				
Coeliac disease	gluten-free	A		
Colitis, ulcerative	semi-fluid, high caloric low roughage	A	B	
Constipation, atonic	high roughage and fat	A		
Constipation, spastic	bland, low roughage	A		
Diarrhoea	—	A		
Dysphagia	semi-fluid, high caloric low roughage	A		
Dyspepsia	—	A		
Gastritis	—	A		
Pancreatic failure	high protein, low fat	A		
Peptic ulcer	—	A		
Steatorrhoea	high protein, low fat	A		
Fevers	semi-fluid, high caloric	A		
Fractures	high calcium	A		
Gout	moderate caloric, low protein	A		
Heart Disease				
Cardiac failure, mild	restricted salt regime	A		
Cardiac failure, moderate	low salt diet	A	B	C
Cardiac failure, severe	minimal sodium (rice-fruit)	A	B	C
Kidney Disease				
Nephritis, acute	low protein	A		
Nephrotic syndrome	high protein, restricted salt	A		

* Required for the first few months, until the patient recognises quantities and exchanges; thereafter often desirable at intervals to maintain control.

Disorders	*Diets needed*	A (do's & dont's)	B (measured amounts)	C (weighing needed)
Kidney Disease (contd.)				
Nephrotic syndrome with marked oedema	high protein, low salt	A	B	C
Liver and gall bladder diseases				
Choleocystitis	—	A		
Cirrhosis	high protein, moderate fat	A	B	
Hepatitis, moderate	low fat	A	B	
Hepatitis, severe	very low fat	A	B	C
Hepatic failure	minimal protein	A		
Obesity	low caloric	A	B	C
Subnutrition	high caloric, high protein	A		

Comment

Several conclusions follow from this analysis—

1. The number of different types of diet with any important therapeutic value is small; they are—

1. Restricted carbohydrate.
2. Gluten-free.
3. Semi-fluid, high caloric, low roughage.
4. High protein, low fat.
5. Low salt.
6. Minimal protein.
7. High protein, low salt.
8. Low fat.
9. Low caloric.

The other diets listed above make only a minor contribution to the treatment of the patient.

2. The majority of therapeutic diets do not go beyond Category 'A'; that is, they can be simply administered by qualitative regulation of the meals, based on a sound list of 'do's' and 'dont's'.

3. It follows, therefore, that an intelligent matron, ward sister or catering officer—armed with such a list—can effectively provide for most of the dietetic needs of practical therapeutics, given adequate instructions.

4. Although the advice and experience of a dietitian are invaluable in seeing that these instructions are properly carried out, with intelligent and trained catering staff, the services of a dietitian would become—in the main—that of a consultant in this connection.

5. It is chiefly in those disorders listed under Category C (above)—where the food should be weighed as served—that the personal supervision of a dietitian is needed. These disorders are:

Diabetes mellitus.
Cardiac failure.
Nephrotic syndrome with marked oedema.
Hepatitis (severe).
Obesity.

It should be added that only a trained dietitian can properly supervise the *qualitative* (A) problems of a gluten-free diet for the rare disorder of coeliac disease.

6. Perhaps the most important job of the dietitian is in outpatient departments dealing with diabetes and obesity. These are not only very common but also life-long diseases. The dietitian is invaluable in educating such patients in the management of their diets, and she should be an established member of the medical outpatient team.

7. It is consequently most important that the education of dietitians should include special training in the management of diabetes mellitus.

APPENDIX E

The menus shown in this Appendix are offered as a guide. They are in use in some Scottish hospitals. The first series is for patients in bed and the second series for ambulant patients or staff. The menus comply with nutritional requirements and they are suitable for use in most types of hospital. A narrower choice may be necessary in certain hospitals meantime; but where the staff have a cafeteria system a wide choice can be offered.

FIRST DAY—MENU

Name ..... Ward..... Diet..... Date	Name ..... Ward..... Diet..... Date	Name ..... Ward..... Diet..... Date .....
BREAKFAST	**LUNCH**	**SUPPER**
.....Porridge .....Cereal .....Milk	.....Cream of Lentil Soup	.....Soup
	.....Roast Pork—Apple Sauce .....Poached Haddock and Egg Sauce	.....Braised Steak, Garni .....Poached Tripe and Onions
	Cold	.....Creamed Potatoes
.....Grilled Sausages .....Bacon	.....Cold Galantine .....Cold Beef .....Salad	.....Bread and Butter Pudding and Custard .....Jelly Whips
.....Tea or Coffee .....Toast .....Rolls .....Butter .....Marmalade	.....Roast Potatoes .....Creamed Potatoes	.....Tea .....Bread .....Butter .....Preserves
	.....Cauliflower and White Sauce	
	.....Syrup Sponge Pudding and Custard .....Stewed Fruit and Custard .....Milk Pudding	
	.....Tea	
(Tick item desired in each category)	(Tick item desired in each category)	(Tick item desired in each category)

Perforated here

Perforated here

SECOND DAY—MENU

Name ..... Ward..... Diet..... Date	Name ..... Ward..... Diet..... Date	Name ..... Ward Diet..... Date .....
BREAKFAST	**LUNCH**	**SUPPER**
.....Porridge .....Cereal .....Stewed Prunes .....Milk	.....Minestrone Soup .....Fried Calves Liver and Bacon .....Minced Steak and Dumplings	.....Soup
	Cold	.....Cottage Pie, Garni .....Poached Eggs
.....Grilled Bacon .....Grilled Tomatoes .....Fried Egg	.....Beef .....Ham .....Salad	.....Chipped Potatoes
.....Tea or Coffee .....Toast .....Rolls .....Butter .....Marmalade	.....Fresh Frozen Peas .....Saute Potatoes .....Boiled Potatoes	.....Caramel Creme .....Fresh Fruit
	.....Mincemeat Tart and Custard .....Meringue and Ice Cream	.....Tea .....Bread .....Butter .....Preserves
	.....Tea	
(Tick item desired in each category)	(Tick item desired in each category)	(Tick item desired in each category)

Perforated here

Perforated here

THIRD DAY—MENU

Name .....
Ward..... Diet.....
Date .....

Breakfast

.....Porridge
.....Cereal
.....Milk

.....Fried Bacon
.....Boiled Farm Eggs
.....Grilled Kippers

.....Tea or Coffee
.....Toast
.....Rolls
.....Butter
.....Marmalade

(Tick item desired in each category)

Perforated here

Name .....
Ward..... Diet.....
Date .....

Lunch

.....Cream of Carrot Soup
.....Grapefruit Cocktail

.....Steak Pie
.....Fried Fillet of Haddock

Cold

.....Pressed Pork
.....Luncheon Meat
.....Salad

.....Lyonnaise Potatoes
.....Croquette Potatoes

.....Buttered Spring Greeos

.....Peach Melba
.....Milk Pudding
.....Biscuits and Cheese
.....Tea

(Tick item desired in each category)

Perforated here

Name .....
Ward..... Diet.....
Date .....

Supper

.....Soup

.....Cold Salmon and Salad
.....Scrambled Egg and Bacon Roll

.....Parsley Potatoes

.....Chocolate Gateaux
.....Stewed Fruit aod Ice Cream

.....Tea
.....Bread
.....Butter
.....Preserves

Tick item desired io each category)

FOURTH DAY—MENU

Name .....
Ward..... Diet.....
Date .....

Breakfast

.....Porridge
.....Cereal
.....Stewed Figs
.....Milk

.....Grilled Sausages and Potato Cake
.....Boiled Eggs

.....Tea or Coffee
.....Toast
.....Rolls
.....Butter
.....Marmalade

(Tick item desired in each category)

Perforated here

Name .....
Ward..... Diet.....
Date .....

Lunch

.....Cream of Tomato Soup

.....Roast Sirloin of Beef and Yorkshire Pudding
.....Curried Eggs and Rice
.....Grilled Fresh Herriogs (2)

Cold

.....Ham
.....Beef
.....Salad

.....Creamed Potatoes
.....Chipped Potatoes

.....Mashed Swede

.....Queens Pudding and Custard
.....Milk Pudding
.....Fresh Fruit
.....Biscuits and Cheese
.....Tea

(Tick item desired in each category)

Perforated here

Name .....
Ward..... Diet.....
Date .....

Supper

.....Soup
.....Orange Juice

.....Chicken Vol-au-Veot
.....Braised Ham, Garoi

.....Saute Potatoes
.....Beans in Tomato Sauce

.....Chocolate Eclairs aod Ice Cream
.....Pioeapple and Custard

.....Tea
.....Bread
.....Butter
.....Preserves

(Tick item desired in each category)

FIFTH DAY—MENU

Name .....
Ward..... Diet.....
Date .....

Breakfast

.....Porridge
.....Cereal
.....Milk

.....Grilled Bacon
.....Poached Egg
.....Cold Ham

.....Tea or Coffee
.....Toast
.....Rolls
.....Butter
.....Marmalade

(Tick item desired in each category)

Perforated here

Name .....
Ward..... Diet.....
Date .....

Lunch

.....Cream of Lentil Soup

.....Roast Lamb—Mint Sauce
.....Fried Fillet of Haddock and Tartare Sauce

Cold

.....Pork Pie
.....Chicken Mousse

.....Buttered Potatoes
.....Jacket Potatoes

.....French Beans

.....Fruit Gateaux and Ice Cream
.....Stewed Plums and Custard
.....Milk Pudding
.....Tea

(Tick item desired in each category)

Perofrated here

Name .....
Ward..... Diet.....
Date .....

Supper

.....Soup

.....Fried Eggs (2)
.....Curried Beef

.....Chipped Potatoes
.....Grilled Tomatoes

.....Peach Tarts and Custard
.....Milk Pudding

.....Tea
.....Bread
.....Butter
.....Preserves

(Tick item desired in each category)

SIXTH DAY—MENU

Name .....
Ward..... Diet.....
Date .....

Breakfast

.....Porridge
.....Cereal
.....Milk

.....Scrambled Eggs
.....Fried Egg
.....Grilled Bacon

.....Tea or Coffee
.....Toast
.....Rolls
.....Butter
.....Marmalade

(Tick item desired in each category)

Perforated here

Name .....
Ward..... Diet.....
Date .....

Lunch

.....Chicken Noodle Soup

.....Vienna Steaks with Brown Onion Sauce
.....Minced Steak and Dumplings

Cold

.....Silverside
.....Ham
.....Salad

.....Saute Potatoes
.....Creamed Potatoes

.....Buttered Cabbage

.....Golden Syrup Pudding with Syrup Sauce
.....Ice Cream
.....Milk Pudding
.....Biscuits and Cheese
.....Tea

(Tick item desired in each category)

Perforated here

Name .....
Ward..... Diet.....
Date .....

Supper

.....Soup
.....Tomato Juice Cocktail
.....Braised Sausages and Green Peas

.....Cold Roast Beef and Salad

.....Croquette Potatoes

.....Stewed Fruit and Ice Cream
.....Fresh Fruit

.....Tea
.....Bread
.....Butter
.....Preserves

(Tick item desired in each category)

SEVENTH DAY—MENU

Name ..... Ward..... Diet..... Date	Name ..... Ward..... Diet..... Date	Name ..... Ward..... Diet..... Date .....
BREAKFAST	**LUNCH**	**SUPPER**
.....Porridge	.....Mixed Vegetable Soup	.....Soup
.....Cereal		
.....Milk	.....Braised Beef, Garni	.....Braised Sausages and Onions
	.....Curried Lamb	.....Fried Fillet Fish and Lemon
	.....Haggis	.....Cold Ham
.....Grilled Bacon	*Cold*	.....Mashed Potatoes
.....Poached Egg		
.....Poached Finnans	.....Beef	.....Stewed Pears and Custard
	.....Ham	
	.....Pressed Pork	.....Tea
.....Tea or Coffee	.....Roast Potatoes	.....Bread
.....Toast	.....Creamed Potatoes	.....Butter
.....Bread		.....Preserves
.....Butter	.....Cauliflower and White Sauce	
.....Marmalade		
	.....Plum Tart and Ice Cream	
	.....Creme Caramel	
	.....Milk Pudding	
	.....Biscuits and Cheese	
	.....Tea	
(Tick item desired in each category)	(Tick item desired in each category)	(Tick item desired in each category)

Perforated here

Perforated here

FIRST DAY—MENU

BREAKFAST

The main items can be combined

Porridge
Cereal
Milk
Grilled Bacon
Fried Egg
Poached Eggs
Tea, Toast, Rolls, Butter, Marmalade

* * *

MID-MORNING

Beverage — Biscuits

* * *

LUNCH

Mixed Vegetable Soup
Roast Gigot Lamb — Mint Sauce
Minced Steak and Dumplings
Gammon
Cold Roast Beef
Cold Bismark Herring
Roast Potatoes — Creamed Potatoes
Cauliflower and White Sauce
Fresh Salad

* * *

Rhubarb Tart and Ice Cream
Stewed Figs and Ice Cream
Ice Cream
Milk Pudding
Biscuits and Cheese

* * *

TEA

Tea, Bread, Butter, Preserves
Cakes — Scones

* * *

SUPPER

Soup
Cold Ox Tongue
Home Made Bridies
Salad
Mashed Potatoes
Creme Caramel
Stewed Fruit and Custard
Tea, Bread, Butter

SECOND DAY—MENU

BREAKFAST

The main items can be combined

Porridge
Cereal
Stewed Prunes
Milk
Scrambled Eggs
Fried Sausages, Baked Beans in Tomato
Tea, Toast, Rolls, Butter, Marmalade

* * *

MID-MORNING

Beverage — Biscuits

* * *

LUNCH

Cream of Leek Soup
Steak and Kidney Pie
Fried Fillet Haddock — Tartare Sauce
Cold Lamb
Cold Beef
Cold Hough
Chipped Potatoes — Creamed Potatoes
Buttered Cabbage
Fresh Salad

* * *

Mincemeat Tart and Custard
Orange Mousse
Meringue Glace — Ice Cream
Milk Pudding
Biscuits and Cheese

* * *

TEA

Tea, Bread, Butter, Preserves
Cakes — Scones

* * *

SUPPER

Soup
Cold Roast Beef and Salad
Fried Eggs
Curried Beef and Rice
Chipped Potatoes
Ice Cream and Caramel Fudge Sauce
Fruit Jellies
Fresh Fruit
Tea, Bread, Butter

THIRD DAY—MENU

BREAKFAST

The main items can be combined

Porridge
Cereal
Stewed Figs
Milk
Bacon and Tomatoes
Boiled Farm Eggs
Poached Finnans
Tea, Toast, Rolls, Butter, Marmalade

* * *

MID-MORNING

Beverage — Biscuits

* * *

LUNCH

Grapefruit Cocktail
Cream of Tomato Soup
Braised Steak, Garni
Lancashire Hotpot
Haggis
Pork Pie
Cold Ham Mousse
Saute Potatoes — Mashed Potatoes
Fresh Frozen Peas
Fresh Salad

* * *

Banana Nut Sundae
Fresh Fruit
Ice Cream
Milk Pudding
Biscuits and Cheese

* * *

TEA

Tea, Bread, Butter, Preserves
Cakes — Scones

* * *

SUPPER

Soup
Fried Steaklets and Onions
Poached Tripe, Onions
Creamed Potatoes
Eve's Pudding and Custard
Jelly Whips
Tea, Bread, Butter

FOURTH DAY—MENU

BREAKFAST

The main items can be combined

Porridge
Cereal
Milk
Grilled Bacon
Fried Egg
Fried Bread and Grilled Sausages
Tea, Toast, Rolls, Butter, Marmalade

* * *

MID-MORNING

Beverage — Biscuits

* * *

LUNCH

Minestrone Soup
Roast Sirloin of Beef — Yorkshire Pudding
Grilled Calves Liver and Bacon
Fried Fillet of Haddock and Lemon
Cold Ham
Cold Pork Pie
Cold Pressed Lamb
Chipped Potatoes — Mashed Potatoes
Swede Turnips
Fresh Salad

* * *

Vanilla Slice and Ice Cream
Trifle De Luxe
Stewed Fruit and Custard
Ice Cream
Milk Pudding
Biscuits and Cheese

* * *

TEA

Tea, Bread, Butter, Preserves
Cakes — Scones

* * *

SUPPER

Soup
Beef Olives
Cottage Pie
Croquette Potatoes
Apple Fritters and Custard
Milk Pudding
Tea, Bread, Butter

FIFTH DAY—MENU

Breakfast

The main items can be combined

Porridge
Cereal
Stewed Prunes
Milk
Grilled Bacon
Poached Egg
Fried Tomatoes
Baked Beans on Fried Bread
Tea, Toast, Rolls, Butter, Marmalade

* * *

Mid-Morning

Beverage — Biscuits

* * *

Lunch

Cream of Lentil Soup
Roast Turkey, Garni
Spaghetti Bolognaise
Cold Roast Beef
Cold Scotch Egg
Cold Luncheon Meat
Roast Potatoes — Creamed Potatoes
French Beans
Fresh Salad

* * *

Plum Tart and Ice Cream
Peach Nut Sundae
Raisin Bread and Butter Pudding
Biscuits and Cheese

* * *

Tea

Tea, Bread, Butter, Preserves
Cakes — Scones

* * *

Supper

Soup
Tomato Juice Cocktail
Grilled Sausages
Shepherd's Pie, Garni
Poached Haddock — Parsley Sauce
Saute Potatoes
Compote of Fruit
Meringue and Ice Cream
Tea, Bread, Butter

SIXTH DAY—MENU

Breakfast

The main items can be combined

Porridge
Cereal
Milk
Grilled Bacon
Fried Egg
Grilled Herring and Mustard Sauce
Tea, Toast, Rolls, Butter, Marmalade

* * *

Mid-Morning

Beverage — Biscuits

* * *

Lunch

Cream of Vegetable Soup
Braised Beef, Garni
Fried Fillet Haddock
Curried Eggs
Creamed Fish au Gratin
Cold Savoury Meat Loaf
Cold Potted Lamb
Cold Beef
Saute Potatoes — Jacket Potatoes
Carrots and White Sauce
Fresh Salad

* * *

Fruit Salad and Ice Cream
Jelly and Ice Cream
Vanilla Gateaux
Milk Pudding
Biscuits and Cheese

* * *

Tea

Tea, Bread, Butter, Preserves
Cakes — Scones

* * *

Supper

Soup
Braised Ham, Garni
Cornish Pasties and Gravy
Scrambled Eggs
Stuffed Bacon Rolls
Mashed Potatoes
Milk Pudding
Eve's Pudding and Custard
Tea, Bread, Butter

SEVENTH DAY—MENU

BREAKFAST

The main items
can be combined

Porridge
Cereal
Stewed Figs
Milk
Fried Bacon
Potato Cakes
Grilled Kippers
Tea, Toast, Rolls, Butter, Marmalade

* * *

MID-MORNING

Beverage — Biscuits

* * *

LUNCH

Brown Windsor Soup
Fried Steaklets and French Fried Onions
Irish Stew
Grilled Bacon, Egg and Sausage
Cold Salmon
Cold Silverside
Cold Galantine
Chipped Potatoes — Mashed Potatoes
Fresh Peas
Fresh Salad

* * *

Lemon Meringue Pie and Ice Cream
Ice Cream and Chocolate Sauce (Hot)
Jam Pancakes
Stewed Plums and Custard
Biscuits and Cheese

* * *

TEA

Tea, Bread, Butter, Preserves
Cakes — Scones

* * *

SUPPER

Soup
Braised Liver and Onions
Home Made Sausage Rolls and Beans in Tomato
Saute Potatoes
Honeycomb Mould
Fresh Fruit
Milk Pudding
Tea, Bread, Butter

APPENDIX F

Monthly Statement of Provision Costs

	Expenditure for month £	*Cumulative Expenditure* £	*Average weekly cost per person fed* £ s. d.
Meats			
Fish			
Vegetables			
Milk			
Eggs			
Fats			
Fruit			
Cereals and Pudding Mixtures			
Beverages			
Preserves			
Bread and Flour			
Confectionery			
Sugar			
Others			
	£	£	£ : :

Budget for Year, £.....

Budget Pro Rata for Period: £

Consumer Days in Period:

Patients

Staff

Average Daily Number of Occupied Beds for the period

Average Daily Number of Occupied Beds for the month

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